Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Susan T. Braswell Month Physician/ Aug 13 2010 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Joseph Richev Hospice If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Funeral Month, Day, Year)
March 18,1947 Days Hours 1 M 2 XX Months 212-48-8127 Director 63 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County Director 1 XX Yes 2 □ No MD N/A Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 21211 U.S.A. 3939 Roland Avenue #604 12. Was Decedent Ever in U.S.
Armed Forces?
1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 1 Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry should be filed within 72 is and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Office Secretary permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Edward Campbell Josephine Lipira 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2 B Somerville Court Baltimore, MD 21234 Andrew E. Braswell (Son) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial XX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 8/16/2010 Glen Burnie, MD 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home. 3631 Falls Road Balto, MD 2121 21. Signature of Foreral Service Licensee, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ metastatic inknown disease or condition Redical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or ilinjury that initiated events Examine Due to (or as a consequence of): attending physician and I for use as the burial-transit certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 ☐ Live Birth 2 ☐ Fetal Gea 4 ☐ Pregnant at time of death Live Birth 2 Fetal death in the past 12 months? within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached to mapleted filled in by the funeral director, page 2 should be detached. g 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown emphysema 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hypertension Arasmell autopsy Schizophrenia 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner?

1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 A Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ည 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work?
1 Yes 2 No 5 Pending Accident Investigation 24 hours after deat Funeral Director: 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Acertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number RID7936 30. Nana and address of party photophilited colleged death (Item 23a) (Type, Print) ,828 N. Eutaw St., Baltimore, MD 21201 House Joseph Richey 31. Date filed (Month, Day, Year) HOSDICE 32. Registrar's Signature State DAMA Registrar

DHMH 17 Rev 7/2009

10-05681 He

-05681 enry Bias		Please Type or Print in Black Indelible Ink. Ensure All Copies State of Maryland / Department of Health and Mental Hyg			0 == 0							
illy Dias		1- For State Certificate of Death		2011 g. No.	2550							
Physicia	an/	,	. Date of Death		3. Time of Death							
edical Exami	ner		July 29, 20	10	1256 hrs							
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 124 South Loudon Avenue Baltimore		4c. County of Death								
Funeral	_	5. Social Security Number 174 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.	8. Date of Birth	(MM/DD/YYYY) 9. Birtl	nplace (State or unk							
Director		217-34-7277 1 X M 2 F 72 Yrs. Months Days Hours Min.	April ‡		intry) MD							
λ.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits							
d tow any		MD Baltimore			1 X Yes 2 No							
arylan 8a-f sl at onc	Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Coun	try?							
the M sa or 2				USA								
th with ems 23 t be no	Funeral	11. Marital Status unle 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specific Never Married 2 Married Armed Forces? Unle 14. Was Decedent of Hispanic Origin? (Specific Never Married 2 Married Married Never Married 15. Was Decedent Ever in U.S. 14. Was Decedent of Hispanic Origin? (Specific Never Married 15. Was Decedent Ever in U.S. 15. Was Decedent of Hispanic Origin? (Specific Never Married 15. Was Decedent Ever in U.S. 16. Was Decedent of Hispanic Origin? (Specific Never Married 15. Was Decedent Ever in U.S. 17. Was Decedent of Hispanic Origin? (Specific Never Married 15. Was Decedent Ever in U.S. 17. Was Decedent of Hispanic Origin? (Specific Never Married 15. Was Decedent Ever in U.S. 17. Was Decedent of Hispanic Origin? (Specific Never Married 15. Was Decedent Ever in U.S. 17. Was Decedent of Hispanic Origin? (Specific Never Married 15. Was Decedent Ever in U.S. 17. Was Decedent Ever in U.S. 17. Was Decedent Ever in U.S. 17. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 19. Was Decedent Ever in U.S. 19		14. Race - Americ White, etc.	an Indian, Black,							
er dear				Specify: blac	k							
turaf Itural	Completed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of wor										
6 172 ho an "ng cal Ex	lete	Elementary/Secondary (0-12) College (1-4 or 5+)	d)		_							
withir piene.	omp	unk 12th unk BA Union Shop Stewart 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (F	iret Middle M	US Posta								
215- e filed tal Hyg ked of	Be C	Henry John Bias Gladys Low	7. Father's Name (First, Middle, Last) UNK (First, Middle, Last) UNK (First, Middle, Maiden Surname) UNK (First, Middle, Last) UNK (First, Middle, Maiden Surname) UNK (First, Middle, Last) UNK (First, Middle, Maiden Surname) UNK (First, Middle, Maiden Surname) UNK (First, Middle, Last) UNK (First, Middle, Maiden Surname) UNK (First, Middle, Middle, Maiden Surname) UNK (First, Middle, Middle, Middle, Middle, Middle, Middle, Middle, Middle,									
MD 21215-0036 d 2 should be filed within 7 lth and Mental Hygiene. In 27 is marked other than numatic event, the Medica	To	19a. Informant's Name/Relationship (Type, Print) Cassandra Yorbrough—Daughter Saltimore City Folice 19b. Mailing Address (Street and Number or Rur 48 1 Baltistan Ct. Ros			Zip Code)							
			Date Ba	20c. Location - City or								
Baltimore, permit. Pages 1 an Department of He Important: If ite		1 X Burial 2 Cremation 3 Removal from State crematory or other place)										
Baltimo permit. Page Department o Important: injury or oth		21. Signature of Funeral Service Lice	h East.	Randallstov Funera. Hom	e							
Dep Den Ba		Nonald S. Birector 1101 E. North Ave. 655 W. Baltimore S	Baltin	Baltimore,	202 MD 21201							
Physician Neolost		23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or refailure. List only one cause on each line.	espiratory arres	st, shock, or heart	Approximate Interval Between Onset and							
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Cardiovascular Disease Due to (or as a consequence of):			Death							
		Sequentially list conditions b.										
	iner	if any, leading to immediate cause. Either Underlying Cause										
d sit	xam	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		•								
D.O. Box 68760, that the death certificate be executed ned by the attending physician and detached for use as the burial - transit	cal Examiner	UNPENDED X AMENDED 8,9,15,17-19a-b,perfh,c907,9/1/10,WS										
50, ite be e hysicia			6,8/25/	2010, WS 23d. Date of delivery								
68760, certificate be nding physici se as the buri	ian/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnance	у		ay Year							
Box 68760, e death certificate be the attending physicied for use as the burned for use	Physician/Med	1 Yes 2 No 9 Unknown Pregnant at time of death 5 Other (Specify)										
P.O. I es that the gned by the detached				acco use contribute to t								
_ & .go e	Completed by	Chronic Alcohol Abuse	1 Yes		ably 4 Unknown							
ord aw req as bee	nplet		24a. Was ar autops perform	y prior to co	opsy findings available ompletion of cause of							
Rec The ficate			1 ✓ Yes 2	No 1 ✓ Ye	2 No							
/ital	o Be	25. Was case referred to medical examiner? 1 Yes 2 No		Residence 6 🗸 Other:	Scene							
in of Vital adding Physician: h After this certific funeral director.	-	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Month Day Year)		ow injury occurred								
- 2 e a	atio	1 V Natural 5 Pending 2 Accident Investigation										
Division of Vital Records, and or Attending Physician: The law requires after death the certificate has been select in by the funeral director, page 2 should the	rtific	Suicide Could not be determined (Specify)	Bf. Location (St or Town, Sta	reet and Number or Rur ate)	al Route Number, City							
Hospit Hospit Hour Funera	-Ce	29a. Certifier	ue to the cause	(s) and manner as state	d.							
Division To the Hospital or Attenct within 24 hours after death To the Funeral Director:	Medical Certification:	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the and manner stated.										
F > F 0	ğ	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mon	th, Day, Year)							
1		O.C.M.E.		July 30, 2010								
57		30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201									
	ate	31. Daté filed (Month, Day, Year) 32. Registrar's Signature										
Regis	trar	WOUT (COIN SOME)										

DHMH 17 Rev 1/2001 OUME 2006

Meredith Charles E	otate of maryland / Dope	artment of Health and Mental H	ygiene 2010 2550								
Physician	Registrar	Tinicate of Death	Reg. No. 2 1 0 2 0 1 0 2 0 1 0 2 0 1 0 0 0 0 0 0								
Medical Examine	Meredith Charles Byers		Month Day Year 1719 hrs								
And I	4a. Facility Name (if not institution, give street and number) 28 Briarcrest Drive	4b. City, Town, or Location of Death Berlin	4c. County of Death Worcester								
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. I										
Director	212-58-1455 1XM 2 F 59	Yrs. Months Days Hours Mir									
à	Usual Residence of Decedent 10a. State 10b. County 10c. City.	Town or Location									
Aaryland 28a-f show any 1 at once. ector			10d. Inside City Limits								
ryland ryland tones	MD Worcester Be	erlin 10f. Zip Code	10g. Citizen of What Country?								
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f shon ratic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	28 Briarcrest Drive	21811	USA								
with t	11 Marital Status 12 Was Decedent Ever in II										
r death w or items r must be	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.) White, etc.								
s after ral", o	Vidowed 4 Divorced if tes, Give year or Dates:	1 Yes 2 X No specify:	Specify: white								
hours Exam		16a. Decedent's Usual Occupation (Give kind of valuring most of working life. DO NOT use retired.)									
36 in 72 han " dical	Elementary/Secondary (0-12) College (1-4 or 5+) 1 2 4										
21215-0036 build be filed within 72 hour Mental Hygiene. marked other than "natı c event, the Medical Exan fo Be Completed	17. Father's Name (First, Middle, Last)	Entrepreneur	Carpet Restoration (First, Middle, Maiden Surname)								
215 be file ntal Hy rked o ent, th	Meredith Byers		ctoria Tate								
8 4 5 2 1	19a. Informant's Name/Relationship (Type, Print)		Rural Route Number, City or Town, State, Zip Code)								
	Patricia M. Byers-wife	608 Pontiac Avenue,	Baltimore MD 21225								
S l ar of Heg		Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town, State								
imore Pages 1 nent of E sant: If i or other		e View Mem. Garden Aug	.13,2010 Sykesville								
Baltimore, permit. Pages I as Department of He. Important: If ite Important: If ite Important or other tr	21. Si mature of Funeral Service Lice Isee		prose Funeral Home Inc.								
	23a. Part I. Enter the disease, or complications that caused the death.		g Road Arbutus MD 21227								
Physician /Medical	failure. List only one cause on each line.		Between Onset and								
Examiner	Immediate Cause (Final disease or condition resulting in death) Bypertensive Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):										
	Sequentially list conditions, b	,									
iner	if any, leading to immediate Due to (or as a consequence of):									
red sed	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									
	d										
di lijal	x UNPENDED x AMENDED 1,23a,p	t.II,27 per me g907 9-1	-10 vt								
box 68760 the death certificate by the attending physiched for use as the burby sician/Mer	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregr		23d. Date of delivery								
x 687 h certifi tending use as t	past 12 months?		ncy Month Day Year								
Bo e deat the at ed for	1 Yes 2 No 9 Unknown 9 Unknown										
		sulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?								
Records, P.C. The law requires that ficate has been signed a page 2 should be deta Completed by	Hyperlipidemia,Obesity, Chro	onic Alcohol Use and	1 Yes 2 No 3 Probably 4 Unknown								
Division of Vital Records, tal or Attending Physician: The law require is after death. al Director: After this certificate has been sided in by the funeral director, page 2 should bertification: To Be Completed	Heart Failure		24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of								
of Vital Recoing Physician: The law After this certificate has uneral director, page 2 s n: To Be Comp			performed? 1 ✓ Yes 2 No 1 ✓ Yes 2 No								
Vital ysician: his certif director,	25. Was case referred to medical examiner? [Hospital: 1 Insertions 2	26.Place of Death (Check of ER/Outpatient 3 DOA Other	•								
Physical different To	1 Yes 2 No		g Home 5 Residence 6 Other: Scene 28d. Describe how injury occurred								
on of nding Ph. th. r: After the funeral ion: T	1 X Natural 5 Pending (Month, Day, Year)	1 Yes 2 No	280. Describe flow injury occurred								
Division of ital or Attending ital or Attending ital or Attending ital Director: Affilled in by the function:	2 Accident Investigation 28e Place of Injury - At ho		28f. Location (Street and Number or Rural Route Number, City								
Divi	3 Suicide 6 Could not be determined (Specify)		or Town, State)								
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	200 Cortifies	only I Certifying Physician: 10 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
To the How within 24 h To the Fun completely	one) 2 Medical Examiner:On the basis of examination an and manner stated.	d/or investigation, in my opinion, death occurred at	the time, date and place, and due to the cause(s)								
ž Š	29b. Signature and tipe of certifier	190 29c. License number	29d. Date signed (Month, Day, Year)								
	Outer Satter Vell	O.C.M.E.	August 10, 2010								
ϕ	30. Name and address of person who completed cause of death (Item:	·	21201								
-	Victor Weedn MD JD Assistant Medical Examin 31. Date filed (Month, Day, Year) 32. Registrar's Signatur		21201								
State Registrar											

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

			Please	Type or Print AMEND ITEN State of Mar	t in Black	k Indelible InlogENTS, G906,	k. Ensure A 8/17/2010	II Copies A	re Legible.	
			1 - For State Registrar	State of Mai		Certificate of L		Reg.	2111	25504
	Physicia	ın/	1. Decedent's Name (First, Middle, La.	Cooley				2. Date of Death		3. Time of Death
-	Medic	al	4a. Facility Name (if not institution, give		, Ap		r Location of Death	07	20 10 Year 4c. County of Death	12:25p. ^M
		ш	1100 Penn	*	Ave i	513 Balt	more , t	10	Balto.	Cty.
	Funeral Director		5. Social Security Number 6. S 2 13~32-4363 1 Usual Residence of Decedent	ex //. Age (//	n yrs. last birtho	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea	hplace (State or Foreign Intry)	
	/land f show	호	10a. State 10b. County	1	0c. City, Town					10d. Inside City Limits
	or 28a-	Director	MD NA 10e. Street and Number		Ba.	ltimore 10f. Zip Code		100	Citizen of What Cou	1X Yes 2 □ No
	with the s 23a c	Funeral	ll00 Pennsylva	ania Ave A	nt 15		201	109.	II - S - Z	
	r death		11. Marital Status 1 Never Married 2 Married	12. Was Decedent Eve Armed Forces?	rīn U.S.	 Was Decedent of H If Yes, specify Cuba 		cify Yes or No- Rican, etc.)	ican Indian, , etc.	
9036	filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ed by	3 Widowed 4 □ Divorced	1 ✓ Yes 2 ☐ No If Yes, Give Year or Dates.		1 ☐ Yes 🔏 No	Specify:		Specify:	Black
15-0	72 hou n "natı Nedica	Completed	15. Decedent's E (Specify only highest gr	ade completed)	1 (recedent's Usual Occup Give kind of work done of fe. DO NOT use retired)	ation during most of worki	ng 16t	o. Kind of Business I	ndustry
212	iled within I Hygiene. other thar rent, the N		Elementary/Seconday (0-12) 12th grade	College (1-4 or 5+)		Steel Wo	rker	s	parrows	Point
and	be filed ental Hy rked oth ic event	To Be	17. Father's Name (First, Middle, Last)	len Surname)						
ary	should be fil and Mental is marked raumatic ev		James Carter 19a. Informant's Name/Relationship (7)	y or Town, State, Zip	Code) 21217					
e, o	ベイトサ		Jacqueline Cool	.ey-Daught		209 North				ore, Md
mor	nit. Page 1 and 2 should be artment of Health and Men ortant. If item 27 is marke injury or other traumatic e.		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		cemetery,	Disposition (Name of crematory or other place) 1emorial	ce)		Location - City or	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 2 once.		21. Signature of Funeral Service Licens		King i	22. Name and Addre		20/2010	Woodlaw	/II / Ma
	⊕D = 6 0		23a. Part 1. Enter the disease, or com	plications that caused th	e death. Do not	14300 Waba	sh Ave.		ore, Md	21215 Approximate
	Pnysician/		shock, or heart failure. List only of Immediate Cause (Final disease or condition	ne cause on each line.		ial In	Saha.	, respiratory arrest,		Interval Between Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a co	onsequence of)	Λ 1	Tarofron	v		hann
	11-1-3	ner	Sequentially list conditions,	b. Due to (or as a c	onsequence on	1 grt	LA DIS	eel		Years
3	executed ian and irial-transit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	c	m					Years
0	be execut sician and burial-trar		resulting in death) Last	Due to (or as a co	onsequence or)					
876	tificate ng phys	Medi	IF FEMALE:	G						
Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at tir	Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify)	су		23d. Date of deli Month	very Day Year
O. B	sician: The law requires that the decentificate has been signed by the rector, page 2 should be detached	Physi	g 🗌 Unknown	g 🗌 Unknown						
Division of Vital Records, P.O.	res tha signed d be de	by	Part II. Other significant conditions of	July leads but i	not resulting in	the underlying cause giv	ven in Part I.		co use contribute to	the cause of death?
ord	w requi	Completed	DAD.	siac in fi		100		24a. Was an	24b. Were auto	opsy findings available
Rec	: The la cate ha page 3	Com			-			autopsy performed 1 \(\sum \) Yes 2 \(\sum \)	l? death?	ompletion of cause of 2 No
/ital	/sician s certifi	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	2 ☐ EP/Outs	26. Pl	ace of Death (Check		0 T 01 - 10 - 11	6.4
of	ing Phy (fter thii		27. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of injury (Month, Day, Y	28b. Tin	ne of 28c. Injury	y at 2	me 52 Hesidence 28d. Describe how in	e 6 Other (Special njury occurred	<u> </u>
sion	Attend r death ctor: A	Certificate:	2 Accident Investigation 3 Suicide 6 Could not b	e	- At home, farm	M 1	Yes 2 □ No	28f Location (Street	and Number or Rura	al Route Number
<u>N</u>	ital or urs after ral Dire			building, etc. (S	Specify)		,	City or Town, St	ate)	
	Hosp 24 hou Funer leted fil	Medical	(Check 2 L Medical Exam	sician: To the best of my ner: On the basis of exan se Practioner: To the bes	nination and/or i	nvestigation, in my opinic	on, death occurred at	the time, date and pl	ace, and due to the c	ause(s) and manner stated.
	To the within To the comp	2	29b. Signature and title of certifier	se Fractioner. To the bes	st of thy knowled	29c. License	e number		Date signed (Month,	, Day, Year)
			No Mo		1. (1)	0417	-71		07 /201	2010
	(5)		30. Name and address of person who of	completed cause of deat	n (Item 23a) (Ty		t. Ste 300	Baltin	re Mo	21202
	Stat Registra		31. Date filed (Month, Day, Year)	32. Regultrar's	Signature	1				
			JUL GR	Market	A . M.	Contract Contract				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene 23a per dr., g906,08/17/2010dhb Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Nicholas J. Carroll <u>5:55</u> PM^M /Medical July | 31 2010 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1516 Crofton Parkway Crofton Anne Arundel If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Jan 6, 1923 9. Birthplace (State or Foreign Country) Pennsylvania **Funeral** 150 M 2□ F Director 186-18-2568 87 Usual Residence of Decedent 10a State 10h Count 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar mast be retified at 10d. Inside City Limits Director Anne Arundel Crofton 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1516 Crofton Parkway Funeral 21114 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23i any Injury or other traumatic event, the Modical Examinar mast ponee. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No ð white Specify: 3 X Widowed 4 ☐ Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) analyst civil rights 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Nicholas John Carroll Margaret Mary Carney 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timothy Carroll - son 7136 Milbury Court; Elkridge, Maryland 21075 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee ROMALO Wade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street; Baltimore, MD 21201 mi 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Acute Myocardial Infarction** Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SUDDE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Day Year 5 Other (specify) the Tyes 2 No detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 2 No 3 Probably 4 Unknown Completed 1 ☐ Yes been Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy perform 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident death. after death 1 ☐Yes 2 ☐ No filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 360 91

State

DHMH 17 Rev 1/2001

State 31. Date filed (Month)
Registrar

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

OAK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM TO PHYS #10bor Petitru G906 8 17/3010 WS #10g, perfu, G906 8 Certificate of Death Reg. No. 20 For State Registrar 1. Decedent's Name (First, Middle, Last) Noor Nobi Chowdhury 2. Date of Death Physician/ Month 0919M 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Dec 4c. County of Death ASh ION 6 Survie 6. Sex If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 9. Birthplace (State or Foreign 1 X M 2 D F (Month, Day, Year) Months Days Hours Min. Country Director Yrs. 51 2-92-Bangladesh or 28a-f show 10a. State "natural", or items 23a or 28a-f sho 10b. Counts 10c. City, Town or Location death with the Maryland **Funeral Director** 10d. Inside City Limits Anne Arundel Crofton 1 Yes 2X No MD Mille 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 910 Eastham Court Apt T-2 21117 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Narried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Asian Completed 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade 7-Eleven 4yrs Cashier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Bashir Ullah Sahida Begum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sultan Mahamud Limon-Son 910 Eastham Court Apt T-2, Crofton, Md 21114 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) atury of Funeral Service Licensee, 8/12/2010 Memorial Park Woodlawn, King Md 21. Sig Marchad Advers of Weilt t 6.0 4300 Wabash Ave, Baltimore, Md of that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause Interval Between mediate Cause (Final Onset and Death Physician/ rioselerotic disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner betes A Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to for as a consequence on the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): physician a the burial-t Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Day Month Year has been signed by the a e 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed?

Yes 2 No 1 Yes 2 No completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 X Yes Hospital Other: 2 🗆 No ၉ 1 Inpatient 2 PER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide injury 5 Pending 1 Tes 2 No after death Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the i only one) 29b. Signature and title of certifie 29d. Date signed (Montile, Day, Year) eput 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 JONES 11Am filed (Month, Day, Year) 32. Registrar's Signature State AUG 17201 Registrar DHMH 17 Rev 7/2009

NOBBEAUTY

C

00

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25507 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2010 Physician/ Month Samuel T. Collette Jr. 11:10PM Julv Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 11409 Kettering Terrace Upper Marlboro Prince Georges Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Days Hours Min. Director 578-52-7345 71 Wash. 1939 Jùne , DC Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 X Yes 2 No MD Prince Georges Upper Marlboro 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? Funeral 11409 Kettering Terrace USA 20774 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 1 X Yes If Yes, Give 2 🗌 No Maryland 21215-0036 "natural", 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: Black Year or Dates. 57-77 the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) US Military Soldier Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Samuel T. Collette Sr. Annie Burgin 1 and 2 should to of Health and Me fitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Kettering Terrace
Marlboro, MD 20774 ⁹b. Mailing L 1 4 0 9 Gordon Burton/Son Upper Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 July cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 2010 4 Donation 5 Other (Specify) Chesapeake Crematory Beltsville, MD Signature of Funeral Service 22. Name and Address of Facility Austin Royster Funeral Home 3821 14th Street, NW, Wash, DC 20011 M00969 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) ardio umphon 5 mins Medical Due to (or as a consequence of): Examiner cano Sequentially list conditions, Due to los es a consecuencia off cause. Enter Underlying Cause (Disease or iinjury sician and burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Other (specify) Month Dav Year ed by the a detached 1 9 Unknown 9 Unknown P.O. signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ջ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2 autopsy performed? Yes 2 2 N certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 2 🔀 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 XNatural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year,

Sta

State Registrar <u>Tamie</u>

31. Date filed (Month, Day, Year,

AUG 17 2010

Kearns

DHMH 17 Rev 7/2009

Georgia

Walter Reed Medical

Ave., NW, Washington,

Center

DC

20307

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6900

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Angela Marie Carolan 2010 7:30 A Medical Aug 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice #504 Baltimore Timonium Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 23 6. Sex 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 \square M 2 Days Min. 1<u>929</u> Hours Country)
MD **Director** Yrs 216-24-9080 Usual Residence of Decedent 10a. State 10b. County death with the Maryland ms 23a or 28a-f sho must be notified at Director 10c. City, Town or Location 10d. Inside City Limits 1 Tes 2 No MD <u>Baltimore</u> Timonium 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2300 Dulaney Valley Rd. F209 21093 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ural", or iter 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give filed within 72 hours after 1 ☐ Yes 2X☐ No Specify: 3

▼ Widowed 4 □ Divorced white "natural" Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 21215-16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Service Rep. C & P Phone Co. permit. Page 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumment. Be laryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ Lawrence Bockstie Hilda Bittner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Angela Hall/daughter 512 Hawkshead Rd., Lutherville, MD 21093 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 8/19/T0 1

 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Valley Memorial Gardens Timonium, MD Dulaney 21. Signature of Eureral Senuce Dicens 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley,
10 W. Padonia Rd., Timonium, MD 21093 Michael Flagle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) CONGESTIVE HEART FAILURE Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ending physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 X No Pregnant at time of death Day 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital ျှ 1 🗌 Yes 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 \square Nursing Home 5 \square Residence 6 \blacksquare Other (Specify) **HOSPICE** Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifie 29c. Liçense number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

а.ш.

AUGUST

CAROLAN

ANGELA

TIMONIUM, MD 21093

ERNESTINE WRIGHT, MD 2300 DULANEY VALLEY RD.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? [] [] 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Barbara Louise Compitello 6:32 A M 2010 August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) New York **Funeral** (Month, Day, 1 □ M 2 ▼ F Days Hours Min 77 Director 150-24-7920 Nov. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natura" any injury or other traumatic events. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Montgomery Bethesda 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5630 Alta Vista Rd. 20817-3575 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 X Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. White Completed 3 Widowed 4 Divorced Specify 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Howe11 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank E. Compitello / Husband 5630 Alta Vista Rd., Bethesda, MD 20817-3575 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD Chesapeake Crematory! 8/14/2010 21. Signature of Funeral Service ²² Name and Address of Eacility Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MYTASTATIC disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Secuentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ng physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Box 68760 IF FEMALE: detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year g Unknown Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? PLEURAL EFFUSION 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy perform Yes 2 2 🗌 No 1 Yes Hospital or Attending Physician: 24 hours after death. Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2No မ 4 Nursing Home 5 Residence 6 Other (Specify) RE HAP 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending Accident 1 🗌 Yes 2 🗌 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 . Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Hodical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature title of certifier August 12,2010 who completed cause of death (Item 23a) (Type, Print) DAFFIL 5413 W. CIBANLANG #203C BETHESDA, HO 20814 31. Date filed (Month, Day, Year) State Registrar → DHMH 17 Rev 7/2009

2890

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month James Howard Crim 2010 August 5:15 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days Hours 1 X M 2 □ F Months Min. September 23,1941 Maryland 219-36-9400 68 Yrs. **Director** Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Rockville 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5913 Halpine Road 20851 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1960þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced 1962 Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Candy Wholesaler Owner event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev ൧ Calvin Crim Edythe Potts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Allan Crim / Son 23500 Sugar View Drive, Clarksburg, Maryland 20871 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🕅 Bunal 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 16, August Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 2010 21. Signature of Funeral Service Ligenses Robert A. Pumphrey Funeral Home/Rockville, Inc. Ingelette Barris M01305 300 West Montgomery Avenue, Rockville, Maryland 23a. Part 1. After the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Years Immediate Cause (Final Physician/ Prostate Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or iinjury that initiated events resulting in death) Last burial-transi Due to (or as a consequence of): attending physician Physician/Medical law requires that the death certificate be the use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ò Dav 4 ☐ Pregnant at time of death 9 ☐ Unknown be detached the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ecords, Completed 1 ☐ Yes 2 🛛 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No Hospital or Attending Physician: The certificate 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 🗶 No Other: ည 1 M Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify this 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after death Funeral Director: 6 ☐ Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the within 2 To the F 3 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 29d, Date signed (Month, Day, Year) b August 12, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nelson Kalil, M.D. 5454 Wisconsin Avenue, #1300, Chevy Chase, Maryland 20815 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

#20c Per FH G906 817/2010 JH
State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 AUGUST 09:00P M SIDNEY CARTON 11 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BALTIMORE GILCHRIST HOSPICE CARE TOWSON 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 X M 2 □ F Months Days Hours Min. 1273171917 Director 214-14-0824 92 Yrs. Usual Residence of Decedent 28a-f show at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 Tes 2 No BALTIMORE PIKESVILLE MD 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral POMONA EAST, #208 21208 USA items 12. Was Decedent Ever in U.S.
Arged Forces?
1 △ Yes 2 □ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ier than "natural", ເ ; the Medical Exນກ 1 ☐ Yes 2 X No Specify: 3 Divorced Completed Year or Dates WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 5+ **EDUCATOR** EDUCATION Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 DAVID CARTON SOPHIE DUDNICK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GLORIA CARTON / WIFE POMONA EAST, #208, PIKESVILLE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Baltimore 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) SHALOM MEM. PARK 08/13/2010 22. Name and Address of Facility SOL LEVINSON & BROS., Signature of Funeral Service Licensee INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Concesti ve Due to (or as a consequence of): eart. disease or condition resulting in death) very Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): physician and the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant s, outcome of pregnancy
Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ hio Renal well councer 1 \square Yes 2 \square No 3 \square Probably 4 \square Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? phyectomi 24a. Was an has page 2 autopsy performed? Yes 2 X No certificate 2 🗌 No 1 🗌 Yes or Attending Physician: ours after death. eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 X No Other: 1 Tes ပ္ 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 Inpatient 2 ER/Outpatient 3 I 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Yes 2 No 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours at To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier DOUTOLE 50 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N Charles 31. Date filed (Month, Day, Year) AUG 17 2010 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Box 68760

P.0.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	1 - State Registrar		Certificate of L		Reg. No.	2010	25512					
	Physicia	n/	1. Decedent's Name (First, Middle, Last)				-	2. Date of De Month		Year	3. Time of Death			
	Medic		SANDRA		EMA			AUGUST	1 ^{Day}		2:15 A M			
) Examin	er	4a. Facility Name (if not institution, give str			4b. City, Town, or		Death	4c. County of Death BALTIMORE					
2017	Funeral		GILCHRIST HOSPIC 5. Social Security Number 6. Sex	7. Age (In yrs. las	st birtho	TOWSON (ay) If Under 1 Year	If Under 24		th	9. Birthplace (State or Foreign				
	Director		212 - 36 - 5444	M 2X F 71	Y	Months Days	Months Days Hours Min. (Month Day 08/22/				rry) RI			
	d t t	ľ	Usual Residence of Decedent 10a. State 10b. County	10c City	Town	or Location					0d. Inside City Limits			
	ırylan a-f sh fied a	cto	,								1 Yes 2 No			
	or 28%	Dire	MD BALTIMO)KE	KA	NDALLSTOWN 10f. Zip Code			10a. Citiz	zen of What Coun				
	with tu 23a o	Funeral Director	4020 ROUEN ROAD			2113	3	_	9	JSA	,			
	items er mi	Fun		Was Decedent Ever in U.S. Armed Forces?		13. Was Decedent of Hi	spanic Origin	n? (Specify Yes or No-		4. Race - Americ				
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 🛛 Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 X No If Yes, Give Year or Dates.		1 Yes 2 X No		-uerto riioan, etc.,	s	Black, White, e	ITE			
2	hour hatur dical	Completed	15. Decedent's Educ (Specify only highest grade		16a. E	Decedent's Usual Occup. Give kind of work done of	ation	f working	16b. Kin	nd of Business Inc	dustry			
2	hin 72 ne. than '	luo;	Elementary/Seconday (0-12)	College (1-4 or 5+)	Ìi	fe. DO NOT use retired)	umg most o	, wonding						
2	d with	Be C	12 17. Father's Name (First, Middle, Last)		Н	OMEMAKER	19 Mothor	s Name (First, Middle,		OWN HOME				
au	be filed vental Hygrephysic event,	5	JULIUS	ELY			MOLI		maiden de	KUSHN	ER			
ary	2 should Ith and Me 27 is marl		19a. Informant's Name/Relationship (Type		19b. l	Mailing Address (Street a			er, City or T					
Σ	nd 2 sealth an 27 i		LAWRENCE COLEMAN/E	IUSBAND	31	11_WALNUT A	VENUE,	, OWINGS M	ILLS,	MD 21	117			
ore	e 1 ar of He or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R		ace of E metery,	Disposition (Name of crematory or other place	e)	Date	20c. Loc	cation - City or To	wn, State			
ţ	t. Page 1 tment of rtant: If it njury or o		4 ☐ Donation 5 ☐ Other (Specify)	OHE	B S	HALOM MEM.				EISTERST				
22. Name and Address of Facility SOL LEVINSON 8900 REISTERSTOWN ROAD, PIKE											INC. D 21208			
H			23a. Part 1. Enter the disease, or complications that caused the death. De not enter the mode of dying, such as cardiac or respiratory arrest, Approxi											
	Physician,	3 15	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition) Creutz-Coust (Timal disease or condition)											
	Medical Examiner		resulting in death)	Due to (or as a conseque	ence of)	:								
		Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseque	ence of	:				-+				
	rted d ansit	Examiner	cause. Enter Underlying Cause (Disease or linjury											
	execu an an	EX	that initiated events c. The control of the contro											
8760	tificate be executed ng physician and as the burial-transit	Medical	d,											
687	a a	/Me	IF FEMALE:	c. If yes, outcome of pregnan	cv					ood Data of dallin				
Вох	atten atten I for us	Physician/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 Live Birth 2 Fetal 4 Pregnant at time of de	death	3	у			23d. Date of delive Month	Day Year			
В	the d by the	hys	g 🗆 Unknown	9 Unknown										
, P.O.	es that signed be de	by	Part II. Other significant conditions cont	ributing to death but not resu	lting in	the underlying cause giv	en in Part I.	23e. Did t		_	ne cause of death?			
rds	requir	etec							/		osy findings available			
Records,	e law e has l ge 2 s	Completed						auto perfo	psy ormed	prior to co death?	mpletion of cause of			
<u> </u>	an: Th tificate tor, pa	Be Co	25. Was case referred to medical			26. Pl	ace of Death	(Check only one)	2 No	1 L Yes	2 L No			
ξ	ysicia is cer direct	To B	examiner? 1 Yes 2 No	spital:	R/Outp	Loth	ar.	sing Home 5 Resi	dence	Other (Specify	HOUDICE			
o	ng Ph fter th ineral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	28b. Tir inji		at at	28d. Describe I						
ion	ttendi death. tor: A the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	20 81 (1)			Yes 2 N							
Division of Vital	al or Al s after 1 Direc d in by		4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	ne, tarn	i, street, factory, office			n (Street and Number or Rural Route Number, Town, State)					
_	To the Hospital or Attending Physician: The law requires that the death cerwithin 24 hours after death. To the Luneral Director After this certificate has been signed by the attendicompleted filled in by the funeral director, page 2 should be detached for use	Medical	(Check 2 Medical Examine	ian: To the best of my knowle	and/or i	nvestigation, in my opinio	n, death occu	urred at the time, date a	and place, a	and due to the car	use(s) and manner stated.			
	To the vithin; To the comple	Ž	only one) 3 Certifying Nurse 29b. Signature and title of certifier	Practioner: To the best of my	knowled	ige, death occurred at the 29c. License		nd place, and due to th		and manner as sta e signed (Month, I				
	F > F 0		Filler (sperf		121	3932	26	AUG	11)+ 12	, 2010			
	lov		30. Name and address of person who con	npleted cause of death (Item	23a) (Ty	pe, Print)	2101		10:0	mi	7 2011			
	Stat	e	31. Date filed (Month, Day, Year)	32. Registrar's Sanatu	ire /	10.01	K))	- 10W	JW)	1,0	CICUY			
	Registra		AUG 1 7 2010	Burne I.	40	Ver								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year August 8:41 6 PEARL DEHART 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death IVY HALL NURSING REHAB BALTIMORE MIDDLE RIVER 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) Months 1 □ M 2 🔽 F 220-12-8159 94 05/07/1916 VIRGINIA Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD BALTIMORE ROSEDALE 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1810 WILHELM AVENUE 21237 USA 14. Race - American Indian Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify WHITE 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JAS. Η. GOOD DILLAM 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY GEPHARDT/PR-ATTNY 809 EASTERN BLVD SUITE 300 ESSEX, MD 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 08/17/10 BALTIMORE, MD 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee 1211 CHESACO AVE BALTIMORE, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Melastanc 0100 Unknown Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2No 3 Probably 4 Unknown 1 ☐ Yes 24a. Was an autopsy performed Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA

Physician /Medical **Examiner**

burial-tran

as the

asn

for

page 2 certificate

funeral director

filled in by

completely

Medical

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only

this

After

within 24 hours after death To the Funeral Director:

Hospital or Attending

the 0 attending physiclan

the

law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

show

'natural", or Items 23a or 28a-f shov dical Examiner must be notified at

Medical

the

ages 1 and 2 should be fill out of Health and Mental Hit: If item 27 is marked oth y or other traumatic eventy

permit. Pages 1 and 2 should be Department of Health and Menta important; If item 27 is marked any Injury or other traumatic ev

Director

Funeral

2

Completed

Be

2

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examiner Physician/Medical **a** Completed

Be Certification: To

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

> Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

8868 Belair Road Baltmore

28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Injury 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29c. License number

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ww

5 Pending investigation

6 Could not be determined

D0063176

29d, Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

hienyenw9 wachinemere, MD

31. Date filed (Month, Day, Year) 32. Registrar's AUG 1 7 2010

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year n nae 11:45 0 18451 010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death **Examiner** 4c. County of Death zabeth BALTIMORE wrsing ente Social Security Number 6. Sex n vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age uneral 1 □ M 2 🟋 F Months Days Hours Min. JAN 1928 220-18-9176 82 **Director** MD Usual Residence of Decedent oortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. Cify, Town or Location 10d. Inside City Limits Director MD N/A 1 Yes 2 No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4011 PARKSIDE DRIVE 21206 USA within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, rmed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: If Yes, Give 3 Widowed 4 Divorced Specify: Completed WHITE Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b Kind of Business Industry (Specify only highest grade completed) should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) CLERICAL RETAIL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 LEONARD F. BACK ELLEN E. O'ROURKE 19a. Informant's Name/Relationship (Type, Print)
ELAINE SMITH-NIECE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1224 STEVENS AVE HALETHORPE, MD 21227 1 and 2 s of Health item 27 Baltimore, 20a. Method of Disposition
1 → Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite 20c. Location - City or Town, State Date cemetery, crematory or other place 4 Donation 5 Other (Specify) BALTIMORE, MD CATHEDRAL CEM. 8/16/10 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, an. BELAIR RDBALTIMORE. MD 21206 23a. Part 1. Enter the disease, shock, or heart failure, Lis or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line Immediate Cause (Final Onset and Death Physician/ ers **1edical** resulting in death) Due to (or as a consequence of): miner OMIVU Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burlar-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 L 9 Unknown g Unknown P.O. F Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by rial 5ma 2 No Records, 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? notheroidism 24a. Was an autopsy performed? Yes 2 X No leep annea 1 ☐ Yes 2 ☐ No 25. Was case referred to merical examiner? **Division of Vital** Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) Hospital: 2 X No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 X Natural injury 5 Pending 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month. Dav. Year) 1000

State Registrar 30. Name and address of person who completed

31. Date filed (Month, Day, Year)

AUG 1 7 2010

N11) 3320

DHMH 17 Rev 7/2009

2122

oma

cause of death (Item 23a) (Type, Print)

10-05990 Markeif Dales Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

eif Dales		State of Maryland / De 1-For State Registrar	Certificate of		ygierie Reg. 1		25515					
Physici lical Exam		Decedent's Name (First, Middle,Last)			Date of Death Month Da	av Year	3. Time of Death					
ilcai Exam	mer	MARKIEF DALES 4a. Facility Name (if not institution, give street and number)		lb. City, Town, or Location of Death	August 9, 20	10 4c. County of Death	2013 hrs					
		Johns Hopkins Hospital		Baltimore								
Funeral		5. Social Security Number 6. Sex 7. Age (In yr	rs. last birthday)	If Under 1 Year If Under 24Hrs Months Days Hours Min		/M/DD/YYYY) 9. Birt Foreig	n					
Director	i		34 Yrs.		JULY 20		intry) MD					
any		Usual Residence of Decedent 10a. State 10b. County 10c. C	City, Town or Locati	on	-		10d. Inside City Limits					
* *	L		,			1 X Yes 2 No						
Maryland 28a-f show datonce.	Director	10e. Street and Number	BALTIMORE	10f. Zip Code	Citizen of What Cour	try?						
215-0036 be filed within 72 hours after death with the Maryland mal Hygiens male Hygiens ket other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at once.		810 N. MILTON AVE.		21205	US	SΔ						
h with ems 23 Lbeng	Funeral	11. Marital Status 12. Was Decedent Ever in	s Decedent of Hispanic Origin? (Spes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Americ White, etc.	can Indian, Black,						
or deat	Fun	1 Yes 2 X No	0		Triodii, oto.,		717					
irs afte iural" imine	by	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed		Yes 2 No specify: t's Usual Occupation (Give kind of v	vork done 16	Specify: BLA						
72 hou n "nau al Exs	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		ost of working life. DO NOT use reti			,					
21215-0036 21215-0036 Juld be filed within 7 I Mental Hygiene. I marked other than ic event, the Medica	ldm	12TH		CONSTRUC	TION							
71 213-UU30 Id be filed within 72 hours after Aental Hygiene. narked other than "natural", event, the Medical Examiner		17. Father's Name (First, Middle, Last)	LABC	18.Mother's Name	(First, Middle, Maid	len Sumame)						
6 a 6 d	o Be	unk 19a. Informant's Name/Relationship (Type, Print)	PATRICIA Address (Street and Number or F		City or Town State	Zin Codo)						
MD 2 shoulth and I m 27 is raumatic	-	PATRICIA DALES/MOTHER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 810 N. MILTON AVE., BALTIMORE, MD 212										
		20a. Method of Disposition 20		tion (Name of cemetery,	Date 20	c. Location - City or	Town, State					
Dalumore, permit. Pages I ar Department of Hee Important: If ite injury or other tr		1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:				5712 O'DON	NELL ST. MD 21224					
mit. partm porta ury o		21. Signature of Funeral Service Licens e	22. N	ame and Address of Facility WEC	SLEY CHAVI	IS, JR. FN	RL. HM.					
		Wherey havin	2	007-09 EASTERN A	VE., BALT	TIMORE, ME	21231					
Physician /Medical		23a. Part I. Enter the disease, or complications that raised the defailure. List only one cause on each line.			r respiratory arrest,	shock, or heart	Approximate Interval Between Onset and					
Examiner		Immediate Cause (Final disease a. Cocaine Intoxication or condition resulting in death) Due to (or as a consequence of):										
		or condition resulting in death) Due to (or as a consequence b	e or).									
	ner	if any, leading to immediate cause. Enter Underlying Cause	e of):									
	cami	if any, leading to immediate cause. Enter Underlying Cause (Dispass or highly that initiated events resulting in death). Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										
oU, te be executed nysician and burial - transit		d										
be exe	ledical			er me g906 8-27-								
C 68 / 60, certificate be e ending physicia use as the buria	/We	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnant in the		al death 3 Ectopic pregna		23d. Date of delivery	None Year					
lox 68/6 leath certificate e attending phy for use as the	Physician/M	past 12 months?		licy	Month D	ay Year						
1 5 E 2 1	hys	1 Yes 2 No 9 Unknown 9 Unknown										
requires that the been signed by a	by P	Part II. Other significant conditions contributing to death but no	ot resulting in the ur	nderlying cause given in Part I.		co use contribute to t	he cause of death?					
quires quires en sig					24a. Was an		opsy findings available					
law re	ompleted				autopsy performed	prior to co	ompletion of cause of					
	Con				1 Yes 2		2 No					
tending Physician: The cath. or: After this certificate the funeral director, page	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2	✓ ER/Outpatient	26 Place of Death (Check of 3 DOA Other Nursin		idence 6 Other:						
ding Phy L After thi funeral d	<u>ا</u>	1 ✓ Yes 2 No 1 Inpatient 2 2 27. Manner of Death 28a. Date of Injury (Month, Day, Year)	28b. Time of In		28d. Describe how							
	tio	Pending Fd 8-9-10	unk.p.n	1 Yes 2 X No	unknown							
0 4 5 5 V	ertification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - A	_		28f. Location (Stree	et and Number or Rur	al Route Number City					
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Cert	4 Homicide determined (Specify) stre	et		Pk. Ave.	Balto, Md	al Route Nymber City c of Patter 21205					
To the Hospital within 24 hours To the Funeral completely filled		29a. Certifier 1 Certifying Physician: To the best of my knowl (Check only 1 Physician: To the best of my knowl one)	-									
To the Ho within 24 To the Fu completel	Medical	one) 2 Medical Examiner: On the basis of examination and manner stated. 29b. Signature and title of certifier	ii anu/or investigati	on, in my opinion, death occurred a								
_	-	29b. Signature and title or certifier		O.C.M.E.		d. Date signed <i>(Mon</i> ugust 10, 2010	iri, Day, rear)					
L		30. Name and address of person who completed cause of death (It	tom 23a)	J.O.IVI.E.								
Nº		Ling Li, MD Assistant Medical Examiner 1:		t, Baltimore, MD 21201								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Velma M. Driever Medical August 2010 7:00PM 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Lutheran Village Carroll Westminster 5. Social Security Number Age (In yrs. last birthday) If I Inde If Under 24 Hrs 8. Date of Birth **Funeral** Birthplace (State or Foreign Country) (Month, Day, 1 🗆 M 2 🗓 F Months Hours Director 90 214-16-5802 Feb. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho dical Examiner must be notified at Director 10d. Inside City Limits 1 Yes 2 No Carroll Westminster 10f. Zip Code 10g. Citizen of What Country? Funeral 250 Saint Luke Circle, Apt. 508 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces or . 1 ☐ Yes 2 🔀 No If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 ☐ Widowed 4 🏋 Divorced Year or Dates White event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) l Hygiene. other thar Elementary/Seconday (0-12) College (1-4 or 5+) Customer Service Black & Decker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Mental F မ Page 1 and 2 should be Avery Greene Maude Norris is mg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Diana Parr Important: If item 2 any injury or other <u>Daughter</u> Baltimore, <u> 12248 Summer Sky Path, Clarksville, MD 21029</u> 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of cemetery, crematory or other place) ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll 8/13/10 Cremation Hampstead, MD . Signature of Fuyleyal Service Licens 22. Name and Address of Facility 11824 Reisterstown Road Eline Funeral Home Reisterstown, MD 21136 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph.sician/ 10 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death Month Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Completed 1 Yes 2 No 3 Probably 4 Unknown . Were autopsy findings available prior to completion of cause of 24a, Was an After this certificate has autopsy 1 Yes 2 No ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes 2 X No Other: 잍 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 1 Inpatient 2 ER/Outpatient 3 IDOA Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work n 24 hours after death.

e Funeral Director: A pleted filled in by the fu 1 🗌 Yes Accident 2 🗌 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 25517 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Ida Mae Elizabeth Davis 2010 9:25a August Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A Baltimore <u>Manor Care Rol</u>and Park Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Maryland Maryland 1 🗆 M 2 🕱 F Months Hours Nov. 24, 1922 220-13-1127 **Director** 87 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d, Inside City Limits 10c. City, Town or Location event, the Medical Examiner must be notified at Director 1 🗌 Yes 2 🏝 No Baltimore N/A Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral 2118 Callow Avenue Apt #3 United States 21217 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes If Yes, Give 2 XNo 1 Yes 2 No Specify: **Black** Specify: 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, th. N Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edith Viola Raphael Thomas Jefferson Vaughn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2118 Callow Avenue Apt#3, Baltimore, Maryland 21217 Brian Davis, Son 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1

Burial 2

Cremation 3

Removal from State 8/16/2010 Baltimore, Maryland 4 Donation 5 Other (Specify) Metro Crematory, Inc. 22. Name and Address of Facilit Cremation Society of Maryland, Inc. 21. Signature of Funeral Service Licensee Amanda Heaston 299 Frederick Road, Baltimore, Maryland 21228 Heaston 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month ed by the detached 1 ☐ Yes 2 ≥ 9 ☐ Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. within 24 hours after death.

To the Funeral Director: After this certificate has been signed I completed filled in by the funeral director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one the 29b. Signature and title of certified 0006931 ltham Woods Name and address of person State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene

		1	For State State Registrar	of Maryland / Depa Cer	tificate of Death	and Mental rive	Reg. No. 2010	25518			
	Physicia		Decedent's Name (First, Middle, Last) Louis Dou	glas		2. Date of Dea Month	Day Year	3. Time of Death 0603 M			
	Medic Examin		4a. Facility Name (if not institution, give street and not Montgomery General Hosp		4b. City, Town, or Location Olney	n of Death	4c. County of Death Montgomery	7			
3"	Funeral Director		5. Social Security Number 577–56–3090 6. Sex 1 ₺ M 2 □ F	7. Age (In yrs. last birthday)	If Under 1 Year If Und Months Days Hours	ler 24 Hrs. 8. Date of Birth Min. (Month, Day 03/22/					
	land show dat	tor	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	shington			10d. Inside City Limits 1 ☐ Yes 2【 No			
	the Mary or 28a-1 e notifie	Director	DC 10e. Street and Number	Wa	10f. Zip Code		10g. Citizen of What Cou				
	ath with ems 23a must b	Funeral	1537 3rd st. NW 11. Marital Status 12. Was De	cedent Ever In U.S. 13. V	20001 Vas Decedent of Hispanic	Origin? (Specify Yes or No- can, Puerto Rican, etc.)	USA 14. Race - Ameri	can Indian,			
9036	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If if item 27 is marked other than "natural", or items 23a or 28a-f show if item 27 is marked other than "natural", or items 2a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	ል	1 Never Married 2 Married 1 Republic 1 September 1 Never Married 2 Married 1 Yes, C Year or	s 2 MNo Rive 1 Dates.	☐ Yes 2 <mark>X</mark> No <i>Sp</i> ec		Specify.	lack			
1215-(hin 72 hou ne. than "nat te Medica	Completed	15. Decedent's Education (Specify only highest grade complete Elementary/Seconday (0-12) College	(Give I	dent's Usual Occupation kind of work done during m O NOT use retired) Ser Superviso		Government	ndustry			
73	be filed wit antal Hygie ked other c event, th	To Be C	17. Father's Name (First, Middle, Last) William Douglas			other's Name (First, Middle, B	Maiden Surname)				
Maryl	12 should be file lith and Mental 27 is marked or r traumatic eve		19a. Informant's Name/Relationship (Type, Print) Ethel Douglas/Wife	r, City or Town, State, Zip	Code)						
á,	Page 1 and 3 ment of Healt ant: If item 2 ury or other		20a. Method of Disposition 1	8-21-10	20c. Location - City or Town, State Suitland, MD						
Balti	permit. Page 1 Department of Important: If i any injury or once.		21 Tature of Fineral Service Licentee	1 22	2. Name and Address of Fa 08 W. North	Ronald Tay Ave. Baltimo	lor II FH re, MD 2120	1			
	Pnysician Medical Examiner	rest,	Approximate Interval Between Onset and Death								
).	physician and the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or linjury	to (or as a consequence of):	deute renal	0					
Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Physician/Medi	in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of del Month	ivery Day Year			
s, P.O.	v requires that th s been signed by should be detac	ξ	Part II. Other significant conditions contributing to	o death but not resulting in the u	underlying cause given in F		obacco use contribute to Yes 2 🗫 No 3 □ Pi				
Records,	The law requirate has been page 2 shoul	Completed				24a. Was auto perfc 1 □ Yes	psy prior to o	topsy findings available completion of cause of			
Vital	ysician: The is certificate director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	Inpatient 2 ☐ ER/Outpatie	Others	Death (Check only one) Nursing Home 5 Resi	dence 6 Other (Spec	ify)			
n of	iding Phy th. After thi funeral			ate of injury Ionth, Day, Year) 28b. Time o injury	f 28c. Injury at work? M 1 \sum Yes 2		how injury occurred				
Division of Vital	I or Atter after dea Director	Certificate:	3 Suicide 6 Could not be 28e. Pla	ace of Injury - At home, farm, strilliding, etc. (Specify)	reet, factory, office	28f. Location (City or Tou	Street and Number or Ru wn, State)	ral Route Number,			
	2 Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route No. City or Town, State) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Specify) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)										
	To the virthing compared to the compared to th	-	29b. Signature and title of certifier M 9in	h	29c. License numb		August 1	h, Day, Year) 20 10			
	20		30. Name and address of person who completed of	18101 Grina	Philip Dr	, Olney , N	17 2083	2			
	Sta Registr		31. Date filed (Month, Day, Year)	Registrar's Signature	,	J					

10-05931 Donald Duvall Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 255 | 9

The control by Service First Messolution Donal Dura Dura Donal Dura Don			1- For State Registrar		Certific	ate of D	eath		R	eg. No.	20013
Dona 1d. Drum Duvol1 Security Four Protection Plants and makes Sile Cold Georgeton Road @ R1 486 Foureral Sile Cold Georgeton Road & River Sile Cold Road & River		n/		dle,Last)							
SSO DIG Georgetown Road @ RT 495 Separation Separati	Medical Examii	ner								2010	0855 nrs
Second Security Funds							•	ation of Death			
100 100											
Constitution Contracts C					7. Age (In yrs. last bir	_			Caralan		
The state of the control of the cont	Director		219-46-8448	1XM 2F	64		World's Days I	I IOUI 5	03/07	/1946	Warshington, DC
Montgomery Chevy Chase Section of Windows American Process Sectio											
The state of the s	w anj				1						
The state of the s	and show	5	MD Mont	gomery	Chev	y Chas	e				
The state of the s	Maryl 28a-1	ect	10e. Street and Number			1	0f. Zip Code		1	0g. Citizen of Wha	at Country?
The state of the s	the land		3414 Taylor S	treet			20815			USA	
Part Different Condition Part Different Supplemental Different Condition Part Different Condition Different Conditio	h with	era									
Part Different Condition Part Different Supplemental Different Condition Part Different Condition Different Conditio	or ite	The ver married 2 IX Yes 2 No									
Part Different Condition Part Different Supplemental Different Condition Part Different Condition Different Conditio	s after ral",			or Dates:			-			оросиу.	
Part Different Condition Part Different Supplemental Different Condition Part Different Condition Different Conditio	hour	8								16b. Kind of Bus	iness/Industry
Part Different Condition Part Different Supplemental Different Condition Part Different Condition Different Conditio	36 in 72 han "	흶	Elementary/Secondary (0-12)) College (siness	Developm	nent Ma	nager	Consult	ting/Contracts
Part Different Condition Part Different Supplemental Different Condition Part Different Condition Different Conditio	with spiene ber t	E	17 Father's Name (First Middle	a Last\							8,
Part Different Condition Part Different Supplemental Different Condition Part Different Condition Different Conditio	filed filed ed of	ပ	, .	•						valuen ourname)	
Part Different Condition Part Different Supplemental Different Condition Part Different Condition Different Conditio	212 ald be Menta nark even	B	<u>-</u>		19	b. Mailing Ad				nber. City or Town	State, Zip Code)
Part Different Condition Part Different Supplemental Different Condition Part Different Condition Different Conditio	Shou and I	ᅦ			N.	_	•				
Part Different Condition Part Different Supplemental Different Condition Part Different Condition Different Conditio	and 3	- 1			20b. Place	of Disposition	n (Name of cemeter	ry,	Date	20c. Location -	City or Town, State
Part Different Condition Part Different Supplemental Different Condition Part Different Condition Different Conditio	Ore ges 1 t of F : If i		1 Burial 2 Crematio	on 3 Removal f	John State	•				1	
Physician fallure. List only one cause on each line. 23a. Part Lifer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 25a. Part List only one cause on each line. 25a. Part List only one cause on each line. 25a. Part List only one cause on each line. 25a. Part List only one cause on each line. 25a. Part List only one cause on each line. 25a. Part List only one cause on each line. 25a. Part List only one cause on each line. 25a. Part List only one cause on each line. 25a. Part List only one cause on each line. 25a. Part List only one cause on each line. 25a. Part List only one cause on each line. 25a. Part List only one cause on each line. 25a. Part List only one cause on each line. 25a. Part List only one cause on each line. 25a. Part List only one cause on each line. 25a. Part List only one cause on each line. 25b. Use to or as a consequence of): 25a. Uniform 1	timen ritant	-			Montgo						
Physician flate. Little file flates asset or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory areast, shock, or near a flate. Little flate flate disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory areast, shock, or near a flate. Little flate f	Bal Permi Depar Impo injur	-	21. Signature of Publish Service	e Licerisee	7	Robe	rt A. Pur	nphrey	Funeral H	Home, Inc. E	Bethesda-ChevyChas
Fallure List only one cause on each line. Fallure List only one list one cause on each line. Fallure List only one cause on each line. Fallure List onl		\dashv	23a, Part I, Enter the disease, o	or complications that	caused the death. Do n	ot enter the r	Wiscons node of dying, such	in Avei nas cardiac o	r respiratory arr	nesda, Ma est, shock, or hea	rt Approximate Interval
The state of the s			failure. List only one cause	e on each line.			, ,				Between Onset and
Sequentially list conditions, fary, leading to immediate cause. Enter Underlying Cause (Conditions), fary, leading to immediate cause. Enter Underlying Cause (Conditions), fary, leading to immediate cause. Enter Underlying Cause (Conditions), fary, leading to immediate cause. Enter Underlying Cause (Conditions), fary, leading to immediate cause. Enter Underlying Cause (Conditions), fary, leading to immediate cause. Enter Underlying Cause (Conditions), fary, leading to immediate cause. Enter Underlying Cause (Conditions), fary, leading to immediate cause. Enter Underlying Cause (Conditions), fary, leading to immediate cause. Enter Underlying Cause (Conditions), fary, leading to immediate cause. Enter Underlying Cause (Conditions), fary, leading to immediate cause. Enter Underlying Cause (Conditions), fary, leading to immediate cause. Enter Underlying Cause (Conditions), fary, leading to immediate cause. Enter Underlying Cause (Conditions), fary, leading to immediate cause. Enter Underlying Cause (Conditions), fary, leading to immediate cause. Enter Underlying Cause (Conditions), fary, leading to immediate cause. Enter Underlying Cause (Conditions), fary, leading to immediate cause. Enter Underlying Cause (Conditions), fary, leading to immediate cause. Enter Underlying Cause (Conditions), fary, leading to immediate cause (Conditions), fary, leading to immediate cause. Enter Underlying Cause (Conditions), fary, leading to immediate cause. Enter Underlying Cause (Conditions), fary, leading to immediate cause	Examiner	-									
The composition of class and the contribution of the contributio		٦	Convention list conditions	b.							
The plant of the p		ě	if any, leading to immediate		a consequence of):						
The plant of the p		ᇍ	(Disease or injury that initiated	C.	a consequence of						
Text	ted I unsit	۱Ä	events resulting in death) Last	- '	a consequence or;						
Past 12 months? Type Description Desc	execu an and	[g	UNPENDED	¬							·
Past 12 months? Type Description Desc	30, te be buriz	Ę			outcome of programmy					23d Date of c	delivery
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?	876 tifica ng ph as the	- C	23b. Was decedent pregnant in t		In laste		death 3 E	ctopic pregna	ncy		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?	th cer			, , ,	to the contract of the sales						
and manner stated. 29b. Signature and title of certifier 29c. License number O.C.M.E. August 8, 2010 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	Bo e dea the a	hys		9 Uliki							
and manner stated. 29b. Signature and title of certifier 29c. License number O.C.M.E. August 8, 2010 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	o hat th		Part II. Other significant condi	tions contributing t	to death but not resultin	ig in the unde	erlying cause given	in Part I.	11		
and manner stated. 29b. Signature and title of certifier 29c. License number O.C.M.E. August 8, 2010 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	ires t sign d be o	힜									
and manner stated. 29b. Signature and title of certifier 29c. License number O.C.M.E. August 8, 2010 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	rds v requ										
and manner stated. 29b. Signature and title of certifier 29c. License number O.C.M.E. August 8, 2010 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	ecc he lav tte ha	Ĕ								med? de 2 No 1	eath? ✓ Yes 2 No
and manner stated. 29b. Signature and title of certifier 29c. License number O.C.M.E. August 8, 2010 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	Triffica		25. Was case referred to medical	al			26.Place of D	eath (Check	only one)		
and manner stated. 29b. Signature and title of certifier 29c. License number O.C.M.E. August 8, 2010 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	Vita Visicia ysicia direci			Hospital: 1	Inpatient 2 ER/0	utpatient 3	DOA Othe	4 Nursin	g Home 5	Residence 6	Other: Scene
and manner stated. 29b. Signature and title of certifier 29c. License number O.C.M.E. August 8, 2010 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	of ug Ph			28a. Date	e of Injury 28b.	Time of Injur	y 28c. Injury at				d
and manner stated. 29b. Signature and title of certifier 29c. License number O.C.M.E. August 8, 2010 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	On endii or: /	흷	Pen	iding	2010 084	5 hrs	1 Yes	2 🗸 No	Driver auto	auto comsion	
and manner stated. 29b. Signature and title of certifier 29c. License number O.C.M.E. August 8, 2010 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	ViSi or Att her de nirect in by	<u>[2</u>		28e Plac	ce of Injury - At home, f	arm, street, fa	actory, office buildin	ng, etc.			r or Rural Route Number, City
and manner stated. 29b. Signature and title of certifier 29c. License number O.C.M.E. August 8, 2010 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	Dital Oital ours all lilled	E I	dete	and and	Major Road / H	ighway		}			RT 495, Bethesda, Md.
and manner stated. 29b. Signature and title of certifier 29c. License number O.C.M.E. August 8, 2010 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	Hosp 24 ho Fune			Physician: To the be	est of my knowledge, de	ath occurred	at the time, date ar	nd place, and	due to the caus	e(s) and manner a	as stated.
29b. Signature and title of certifier O.C.M.E. August 8, 2010 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	o the orthin orthin omple	4 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the care and manner stated.									
30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	F 2 F 5	ž	29b. Signature and title of certifi				29c. License nur	mber		29d. Date signer	d (Month, Day, Year)
Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201			Mouhante	The Whil	i		O.C.M.E			August 8, 20	010
, ,	1.1		30. Name and address of persor								
State 31. Date filed (Month, Day, Year) Registrar ALIC 17 2010	1		•				n Street, Baltin	nore, MD 2	21201		
The state of the s			31. Date filed (Month, Day, Year)	32. R	egistrar's Signature	Kel					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 _ State	laryland / Depa Cen	rtment of Healt tificate of Deat		tal Hygien Reg. N	-2010	25520				
		Registrar 1. Decedent's Name (First, Middle, Last)		inouto or bout	2. 0	Date of Death		3. Time of Death				
and the same of th	dical	Taoping bai			Au	igust 1	1°, 2010	7:30 AM				
Exan	niner	4a. Facility Name (if not institution, give street and number) 10809 Maple Crest Lane		4b. City, Town, or Locati	ion of Death		4c. County of Death Montgom	ery				
Funer		5. Social Security Number 6. Sex 7. A	ge (In yrs. last birthday)	If Under 1 Year If Un Months Days Hou		Date of Birth	9. Birthp	lace (State or Foreign				
Directo	_	219-17-1355 1 M 2 M F Usual Residence of Decedent	46 Yrs.	Monato Suyo Mas	Ma	Month Day, Year y 8, 19	64 China	i''				
land show dat	į	100 0	10c. City, Town or Loc	ation			1	0d. Inside City Limits				
Mary 28a-1 notifie	ire C	Maryland Montgomery	P	otomac				1 Yes 2 No				
vith the 23a on st be	Funeral Director	10e. Street and Number 10809 Maple Crest Lane		10f. Zip Code 2085	4		Citizen of What Coun nited Stat	-				
death v items ier mu	i i	11. Marital Status 12. Was Decedent Armed Forces'	t Ever in U.S. 13. W	Vas Decedent of Hispanic Yes, specify Cuban, Mex	Origin? (Specify \	Yes or No-	14. Race - Americ Black, White, e	an Indian,				
after after sal", or xamin	À	1 Never Married 2 Married 1 Yes 2 M	(No	☐ Yes 2 No Spe		,, 0.00,	Specify: Asi					
5-0C hours hatura dical E	atal	15. Decedent's Education (Specificantly highest grade completed)	16b.	Kind of Business Inc	dustry							
121 thin 72 me. than "	3 Widowed 4 Divorced Tes, diversity Specify: Specify:											
iled will Hygie other fent, ti	P B	17. Father's Name (First, Middle, Last)			Nother's Name (Firs	st, Middle, Maide	an Surname)					
ylar Id be f Menta Merked arked	٢	Yong Ning Dai			Xia F	ei Zou						
Maryland 21215-0036 2 should be filed within 72 hours after tht and Mental Hygiene. 27 is marked other than "natural", o traumatic event, the Medical Exam		19a. Informant's Name/Relationship (Type, Print) Frank Zhang /Husband		g Address (Street and Nu Maple Cres				. 1				
Te, 1 and of Heal item		20a. Method of Disposition	20b. Place of Dispos	sition (Name of	1		Location - City or To					
Page ment c ant: If ury or		1 🕅 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		cemetery Cemetery	August 2010	Ge Ge	ermantown,	Maryland				
Baltimore, permit. Page 1 and Department of Hea Important: If item any injury or other	10s. State 10b. County 10c. City, Town or Location 10s. Street and Number 10s. Street											
		23a. Part 1 Enter the disease, or complications that cause shock, or heart failure. List only one cause on each li		Approximate Interval Between								
∼eh siciai Medic		negulation in dentals)	us Cell Cand	er of Left	Tongue			Onset and Death Years				
Examin	_	Due to (or as	s a consequence of):									
	iner	Se uentially list conditions if any, leading to immediate cause. Enter Underlying	s a consequence of):									
ecuted and -transi	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as	s a consequence of):									
Ox 68760 atth certificate be executed attending physician and for use as the burial-transit	edical	d										
876 tificate ing phy	Med	IF FEMALE:										
Box 68 death certific he attending led for use as	by Physician/M	23b. Was decedent pregnant 23c. If yes, outcom in the past 12 months? 4 Pregnant	n 2 🗌 Fetal death 3 🖳	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year				
b. B the de	hvsi	1 Yes 2 No 9 Unknown										
be detached	3	Part II. Other significant conditions contributing to death	but not resulting in the ur	nderlying cause given in f	Part I.		o use contribute to the	ne cause of death?				
rds require been s	eted					24a, Was an		osy findings available				
ecc he law te has l	Completed				**	autopsy performed?	prior to co death?	mpletion of cause of				
tal Fisian; Ti sian; Ti srtifica; ctor, p	Be	25. Was case referred to medical			Death (Check only		10 163	2 110				
of Vil Physic this or ral dire	₽	1 ☐ Yes 2 🗶 No	atient 2 ER/Outpatien	t 3 DOA Other: 4 D		5 X Residence Describe how inj	6 Other (Specify)				
on on nding ath. r: After e fune	icate	1 🛣 Natural 5 □ Pending (Month, D 2 □ Accident Investigation	Day, Year) injury	work? M 1 🗆 Yes		Describe now inj	dry occurred					
Division of Vital Records, tal or Attending Physician: The law requires is after death. In Director: After this certificate has been signed in by the funeral director, page 2 should be	Certificate	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e, Place of Ir building, e	njury - At home, farm, stre etc. (Specify)	et, factory, office		Location (Street a City or Town, Sta	and Number or Rural ate)	Route Number,				
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
the Hithin 24 the Fi	Z	(Check 2 ☐ Medical Examiner: On the basis of only one) 3 ☐ Certifying Nurse Practioner: To the 29b. Signature and the of certifier	ne best of my knowledge, d	leath occurred at the time,	, date and place, an	d due to the caus	se(s) and manner as st Date signed (Month, i	ated.				
≒ ≥ 5 8		I fail Ham	Co	D00610			igust 12,					
		30. Name and address of person who completed cause of	death (Item 23a) (Type, Pedical Cente		100 Pagis	v411c N	Maruland C	20850				
s	state	31 Date filed (Month Day Veer)	tuerle Claneture		oo, Rock	ATTTE 9 1	Taryrand 2	.0000				
Regis		AUG 1 7 2010 Canada	A. Acek									

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dav 1:11 **Physician** 7,2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Pana allstoi 9 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug 3, Birthplace (State or Foreign Country)unk 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 1 ☑ M 2 □ F Yrs. 219-78-6549 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location woye 10a, State 10b. County r then "netural, or iteme 23a or 28a-f ehor the Madical Examiner rust be notified at 1 ☐ Yes 2√ No Owings Mills Director Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21117 9004 Forest Mill Court by Funerai death 14. Race - American Indian, Black, White, etc. 11. Marital Status unk filed within 72 hours after 1 □ Never Married 2 □ Married white Baltimore, Maryland 21215-0036 Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation Unk (Give kind of work done during most of working life. DO NOT use retired) unk Completed 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Coll**eg**e (1-4or 5+) unk Elementary/Secondary (0-12) unk th and Mental Hygie 27 is marked other i r traumatic event, II 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) unk Be Pages 1 and 2 should be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Depertment of Heetth ar Important: If item 27 is eny injury or other trau 5401 Old Court Road; Randallstown, MD 21133 Northwest Hospital 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 ☑Other (Specify) in state 21. Signature of Funeral Savice Licensee Ronald S. Wag 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street; Baltimore, MD 21201 ms Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part1. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Lere /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of ettending physicien and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. icete has been signe r, page 2 should be d Š 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performer certificete 1 ☐ Yes 2000 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient No No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 🗌 Yes 2 ER/Outpatient 3 DOA this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification; After 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 24 hours after d • Funeral Direct 4 Homicide 29a. Certifier ✓ Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s)

1. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s)

2. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s)

2. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s)

3. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s)

4. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s)

4. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s)

4. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s)

4. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s)

4. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s)

4. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s)

4. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place at the time, date and place at the time, date and place at the time, date at Medicai completely (Check only one) and manner stated. within 2 To the 29d. Date signed (Month, Day, Year)

AUSUJ + 7.2015 29c. License number 29b. Signature and title of certified cause of death (Item 23a) (Type, Print) 30. Name and address of preson who completed Northwest てんろ 31. Date filed (Month, Day, Year) 2. Registrar's Sign State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 3. Time of Death 2. Pate of Death 1. Decedent's Name (First, Middle, Last) Physician/ hel Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Itospice - NW andallstank Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 10 25 112 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 □ M 2 💢 F Months Hours Director Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director MD Baltimore 1 🗆 Yes 2 💆 No Kandallston 10g. Citizen of What Country? 10e Street and Number USA Funeral 21133 3012 Edrich Way 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, "natural", or item ledical Examiner n Black, White, etc. Yes 2 No Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black If Yes, Give 3 Widowed 4 □ Divorced Year or Dates. th and Mental Hygiene, 27 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Private Donnestic th arad Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit, Page 1 and 2 should be file Department of Heath and Mental Important: If item 27 is marked c any injuy or other traumatic eve once. Bessie West Daniel Gaulti 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Edrich Way Kandallstown MD 21133 L. Myles 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21/2010 Windsor Hill Menorial Park Vausin C. Greene Funeral Services 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 23a. Part 1. En er the Lisease, or complications that caused the death. Do not enter the mode of dying, such as lardiac or respiratory shock, or leart falure. List only one cause on each line. Immediate Caus (Find disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed nding physician and use as the bunal-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 WNo
9 Unknown Year Month Day Pregnant at time of death been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Tes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy perform Yes 2 No this certificate Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 2 200 1 \square Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of De th 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: within 24 hours after death.

To the Funeral Director: After completed filled in by the funer work? 5 Pending Matural 2 🗌 No ☐ Accident ☐ Suicide Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Pertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 🗹 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Date signed (Month, Dav. Year) 29b. Signature and title of certifier

State Registrar 10-05630

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2010 25523 Terri Freeman State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1 Decedent's Name (First_Middle Last) 2. Date of Death Physician/ Month Day July 27, 2010 1702 hrs Madical Examiner Terry H. Freeman 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Hyattsville 7812 Temple Street 9. Birthplace (State or If Under 1 Year If Under 24Hrs. Date of Birth(MM/DD/YYYY) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Funeral Min 1948 Dec. 14, Director 578-70-6003 Country) Virginia 61 1X M 2 F Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No 23a or 28a-f show notified at once. MD PG Adelphi death with the Maryland Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 7812 temple street 20783 US Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married White, etc. Black 2 Married Yes timore, MD 21215-0036

1. Pages I and 2 should be filed within 72 hours after of ment of Health and Mental Hygene.

The state of the st If Yes, Give Year or Dates: Widowed Divorced Yes 2 No specify ≧ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+ Elementary/Secondary (0-12) 2yrs seafood manager Giant Food 18.Mother's Name (First, Middle, Maiden Surname)
Pauline Waldron 17. Father's Name (First, Middle, Last) Haywood Freeman Be 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) $7812\ Temple\ Street,\ Adelphi,\ MD,\ 20783$ 19a. Informant's Name/Relationship (Type, Print) Kathleen Jackson (friend) 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Itimore, crematory or other place)
Wshington National 1 X Burial 2 Cremation 3 Removal from State 08-02-10 suitland, maryland Donation 5 Other Speg 21. Signature of Funeral Se 22. Name and Address of Facility Dunn & Son Funeral HOme 5635 Eads Street, NE, WASH, DC 20019 Approximate Interval **Physician** Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and failur. List only one cause on each line /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last Physician/Medical red by the attending physician adetached for use as the burial -UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Month Fetal death past 12 months? Pregnant at time of Other (Specify, Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 V Unknown pe Completed certificate has been s ector, page 2 should 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy 2 No Yes 2 V No 1 26.Place of Death (Check only one) funeral director, 25. Was case referred to medical Be Hospital: Other4 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 🗸 Other: Scene After this 1 Yes 28a. Date of Injury (Month, Day,Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification 1 🗸 Natural Yes 2 No Pending within 24 hours after death the Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number August 17, 2010 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Pamela E. Southall, MD Assistant Medical Examiner

DHMH 17 Rev 1/2001

State Registra

31. Date filed (Month, Day, Year)

Registrar's Signature

10-05943 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 25524 Clarence Fenner State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 2139 hrs **Medical Examiner** August 7, 2010 CLARENCE LEE FENNER 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 323 East Lafavette Avenue Apt.A **Baltimore** 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Hours Director Country) MD 1 X M 2 F 1947 218-44-9492 63 APR Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show e notified at once, 1 X Yes 2 No permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or ftems 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at oace. BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 323 E. LAFAYETTE AVE. - 1ST FL. 21202 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 X Yes 3 Widowed 4 X Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: BLACK ş 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12TH LABORER PLANT 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) CLAYTON FENNER LORRAINE HARRISON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DIANE FENNER/SISTER 1019 ARLINGTON AVE., BALTIMORE, MD 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State 5712 O DONNELL ST. crematory or other place 1 X Burial 2 Cremation 3 Removal from State 08/13/2010 BALTIMORE, MD 4 Donation 5 Other Specify: CARMEL 21. Signature of Funeral Service Lice 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 2007-09 EASTERN AVE., BALTIMORE, MD d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Physician Between Onset and failure. List only or cause on each line /Medical Death Narcotic Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of). events resulting in death) Last and transit sician/Medical AMENDED 23a, pt.II, 27, 28a-f per me g907 9-16-10 vt physician a the burial -**X** UNPENDED IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth use as t 3 Ectopic pregnancy Day Fetal death Month Year 2 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Phys detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>о</u> ē 1 Yes 2 ✓ No 3 Probably 4 Unknown Cocaine Use Completed Records, has been s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? page ✓ Yes 2 No 2 No

Hospital or Attending Physician: 24 hours after death. director of Vital this After Director:

Be

Medical

one)

29b Signature and title of certifier

Margarita Korell MD.

AUG 1

1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 DOA Other: Nursing Home 5 Residence 6 🗸 Other: Scene ER/Outpatient 3 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Pending 1 Yes 2 X No fd 8-7-10 fd 9:30pm unknown Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 323 E. Lafayette Ave

28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide 6 X Could not be determined (Specify) house

and manner stated

Balto, 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

August 8, 2010

Apt.

Will true melhul 30. Name and address of person who completed cause of death (Item 23a)

111 Penn Street, Baltimore, MD 21201

OCME

31. Date filed (Month, Day, Year) State Registrar

within 24 hours at To the Funeral E completely filled

Assistant Medical Examiner 32. Registrar' Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Augus 2010 Elizabeth Helen Franks Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE CHEN BURNIE BAUTIMORE WASHINGTON MEDICAL Birthplace (State or Foreign Country) If Under 1 Year **Funeral** 1 □ M 2 🕅 F Days Months Director 216-28-5329 Marvland Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10a. State Director 1 Tes 2XXNo Maryland Anne Arundel Co. Linthicum 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō ms 23a or Funeral 405 Nancy Avenue 21090 United States permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S 11 Marital Status Armed Forces?
1 ☐ Yes 2X No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Specify: 3 X Widowed 4 □ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 12 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mary Elizabeth Shultheiss Joseph Kilroy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Severn, Maryland 8314 New Cut Road Mrs. Kathleen A. Beck/ Daughter PA145 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Veterans Cemetery 08/18/2010 Crownsville, Maryland 22. Name and Address of Facility Singleton Funeral & Cremation . Signature of Euneral Service Licens 1 2nd Ave SW; Glen Burnie, MD 21061 Services PA; M01121 fions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complete shock, or heart failure. List only on the shock of t se on each line TULMON AZY IN SEASE Immediate Cause (Final HPONIC OBGRUTINE Physician/ disease or condition resulting in death) Medical Examiner umor Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical P.O. Box 68760 for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Dav Year 4 Pregnant at time of death n signed by the ar 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy performed 1 ☐ Yes 2 ☐ No this certificate 25. Was case referred to medical **Division of Vital** within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? 2 No Hospital: 1 Yes 1 Inpatient 2 မ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my increase death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature d address of person who eted cause of death (Item 23a) (Type, Print) 11tal 32. Registrar's Sig State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 25526 Certificate of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Frances Gore August 14 2:28 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hospice of the Chesapeake Linthicum Anne Arundel 5. Social Security Number Funeral 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗶 F Days 83 Jully 18. 4927 Director Pennsylvania 210-14-6089 Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director Maryland 1 4 1 Anne Arundel Pasadena 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2929 Lady Astor Court 21122 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ģ 1 Never Married 2 Married Black, White, etc. 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify: permit. Page 1 and 2 should be filed within 72 hours aft. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic avent. Completed 3 X Widowed 4 Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Production Expediter Westinghouse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Frank Snyder Anna Gryck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geraldine D. McCarthy (Daughter) 35 Wood Ibis Way Louisburg, North Carolina 27549 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Pk. 08/18/2010 Glen Burnie, Maryland 21. Signature of Fuperal Service Licensee ²² Name and Address of Facility McCully Folyntak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner lowo Succeentially list conditions if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Leneign been signed by the attending physician and should be detached for use as the burial-tran: Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant yes 12 months?

□ Yes 2 No
9 □ Unknown 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No eral Director: After this certificate I filled in by the funeral director, page death? 2 X No 1 Yes Be 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Hospital ဂ္ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide (Month, Day, Year) 5 Pending 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 100389(2

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (A

101

Glen Burne

21061

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	Registrar			id Meritai r			2552			
					Month	Day Year	3. Time of Death 2355 hrs			
	4a. Facility Name (if not institution, give street and number	r)		r Location of Deat		4c. County of Death	1			
	5. Social Security Number 6. Sex 7. A		If Under 1 Ye		s. 8. Date of Birt		thplace (State or			
	14 <u>A</u> M 2_F	28 _Y		ys Hours Mi	10/5	/81 Foreign Co	untry)			
							10d. Inside City Limits			
tor		Baltimo					1X Yes 2 No			
Direc	804 Seagull Ave		21 2	25	10	Og. Citizen of What Coul USA	ntry?			
ınera	1 Never Married 2 Married Armed Forces	? If					can Indian, Black,			
	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1	Yes 2 N	specify:		Specify: Ame				
eted		during	most of working life			16b. Kind of Business/I				
ошо	17 Esthera Nama (First Middle Leat)									
Be	Alphonso Rogers									
		19b. Mailii 1 0 1 0	ng Address (Stre W. Bal	et and Number or timore	Rural Route Numl	ber, City or Town, State 1t., MD 21	Zip Code) 223			
ı	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from S			metery, 8/2	Date 21/10	20c. Location - City or Balt., MD	Town, State			
4 Donation 5 Other Specify:										
	A.C.	5	126 Bel	air Rd,	Balt.,	MD 21206-	5105			
ļ	failure. List only one cause on each line.		the mode of dying	, such as cardiac d	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and Death			
	and the state of t									
Ē		equence of):								
xami	(Disease or injury that initiated	equence of):					_			
	d. AMENDED									
Med		me of pregnancy	- 1			23d. Date of delivery				
ician	past 12 months? 4 Pregnant at	t time of death		Ectopic pregna	ancy		ay Year			
Phys	9 Unknown	h but not resulting in the	underlying cause	niven in Part I	23e Did toh	acco use contribute to t	he cause of death?			
2		3								
plete					autopsy	y prior to co	opsy findings available ompletion of cause of			
	26 Was asso referred to medical			10 11 101	1 ✓ Yes 2		2 No			
m		ent 2 ER/Outpatien		Othor: -		esidence 6 Other:				
	27. Manner of Death 1 Natural 5 Pending Aug 13, 2010	28b. Time of 2212 hrs	· · · · · ·	·		w injury occurred				
≣Cat	2 Accident Investigation 28e Place of In	ijury - At home, farm, stre					al Route Number, City			
	4 V Homicide determined (Specify) In (3500 Horton St	treet, Baltimore, MD				
edica	(Check only	y knowledge, death occu mination and/or investiga	irred at the time, da ation, in my opinion	ite and place, and , death occurred a	due to the cause(t the time, date ar	s) and manner as stated nd place, and due to the	d. cause(s)			
Š	29b. Signature and title of certifier						h, Day, Year)			
	30. Name and address of person who completed cause of d	leath (Item 23a)	0.0.1							
			nn Street, Balt	imore, MD 21	201					
te · ar	AUG 1 7 2010	Sal								
	Medical Certification: To Be Completed by Physician/Medical Examiner To Be Completed by Funeral Director	Andre A. Graham 4a. Facility Name (if not institution, give street and number University Hospital 5. Social Security Number 217-98-2394 Usual Residence of Decedent 10a. State 10b. County MD 10e. Street and Number 804 Seagull Ave 11. Marital Status 1 Selever Married 2 Married 3 Widowed 4 Divorced If Yes 3 Widowed 4 Divorced If Yes 15. Decedent's Education (Specify only highest grade coe Elementary/Secondary (0-12) College (1-4 or 17. Father's Name (First, Middle, Last) Alphonso Rogers 15. Decedent's Name/Relationship (Type, Print) Jessie Graham/Mother 20a. Method of Disposition 1 Sequentially list conditions 1 Sequentially list conditions 1 Sequentially list conditions, if any, leading to immediate cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause (Usease or Injury that Initiated events resulting in death) 1 Wes 2 No 9 Unknown Part II. Other significant conditions contributing to death 25. Was case referred to medical examiner? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death 27. Marcial Sequential Repeated to medical examiner? 28. Was decedent pregnant in the past 12 months? 29. Signature of Poath 29. Certifier 1 Certifying Physician: To the best of my and manner stated. 29b. Signature and title of certifier 31. Date filed (Month, Day, Year) 32. Registral and manner stated. 33. Date filed (Month, Day, Year) 34. Date filed (Month, Day, Year) 35. Registral	10 10 10 10 10 10 10 10	Table Security Number Se	Andre A. Graham 4. Facily have if not institution, give street and number) 4. Facily have if not institution, give street and number) 4. Facily have if not institution, give street and number) 5. Social Security Number 217 - 98 - 2394 4. Days Hours 5. Social Security Number 217 - 98 - 2394 4. Days Hours 6. Sex	Residence 1. December 3 Name (First, Middle, Last) 2. Date of Death 3. And Tee A. Graham 4. Facility Name (for institution, prive steers and number) 4. Facility Name (for institution, prive steers and number) 4. Facility Name (for institution, prive steers and number) 4. Facility Name (for institution, prive steers and number) 4. Facility Name (for institution) 5. Facility Name (for institution) 6.	Registra: 1 December Name (First, Middle, Latt) 2 December Name (First, Middle, Latt) 2 And Cre A. Graham 4 Facility, Name (for Intellistic), get litter and number) University Hospital 5 Boost Becchi, Number 1 To 98 – 2.39 4			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. No. 20 25528 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ CHARLES GREEN, R. JR **AUGUST** 2010 10:10PM Medical 4a. Facility Name (if not institution, give street and number)
704 BENNINGHAUS ROAD 4b. City, Town, or Location of Death BALTIMORE Examiner 4c. County of Death Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Months Davs Hours Min 4-20-1935 213-34-6904 75 Yrs. MARYLAND Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD N/A BALTIMORE CITY 1 X Yes 2 □ No 10e. Street and Number 704 BENNINGHAUS ROAD 10f. Zip Code 10g. Citizen of What Country? U.S.A. Funeral 21212 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important if item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give KOREAN Year or Dates. 1 ☐ Yes 2 No Specify: 3 Widowed 4 ☐ Divorced Specify: WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) PRINTING BOTCHLER COMPANY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ပ CHARLES GREEN, SR. CATHERINE (TURNER) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, TIMOTHY GREEN/SON 704 BENNINGHAUS ROAD BALTIMORE, MD 21212 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State PARKWOOD CEMETERY 8-18-10 PARKVILLE, 4 ☐ Donation 5 ☐ Other (Specify) MD 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME Signature of Funeral Service License 1211 CHESACO AVE ROSEDALE, MD 21237 Part +: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician. disease or condition resulting in death) CHRONIC ISCHEMIC HEART DISEASE Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter onderlying Cause (Disease or linjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) physician Completed by Physician/Medical of Vital Records, P.O. Box 68760 use as the 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for 4 Pregnant 5 Other (specify) Month Day Year Pregnant at time of death to the Funeral Director. After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 T Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 **X** No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 X No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending injury Division death. Accident Investigation 124 hours after deat e Funeral Director: Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical î 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the only one)

15 V

2010

13,

AUGUST

GREEN

CHARLES

31. Date filed (Month, Day, Year, State AUG 1 7 2010 Registrar

29b. Signature and title of certifier

ERNESTINE WRIGHT.

32. Registrar's Sig

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

2300 DULANEY VALLEY RD.

29c. License number

TIMONIUM,

MD 21093

Date signed (Month, Day, Year)

Isainh bordon 10-06109

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

NK UNK	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. 2010 25529												
Physician Medical Examine	1	Decedent's Name (First, Middl Tsiah	ISI	ah Ema	nuel Go	rdon		-	M	ate of Death	nav Vear	3. Time o	
)		4a. Facility Name (if not institution University Hospital				. City, Town				igust 15,	4c. County of Dea		-
Funeral Director		5. Social Security Number 215 27 7868	6. Sex 1X M 2 F	7. Age (In yrs.	last birthday) 20 Yrs.	If Under 1 Months	Year Days	If Under 24 Hours	Min.		0,1989	Birthplace (St eign Country)MD	I I
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Deparment of Health and Mernal Hypgiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Do Commiscion but Examiner must be injured at	10 be completed by runeral	Usual Residence of Decedent 10a. State MD 10b. County MD 10c. Street and Number 1127 Old Eas 11. Marital Status 1 XNever Married 2 Marital Status 1 Steedent's Education (Specified Status) 15. Decedent's Education (Specified Status) 17. Father's Name (First, Middle, Albert Gotton) 18. Informant's Name/Relations! 19a. Informant's Name/Relations! 19a. Informant's Name/Relations! 19a. Informant's Name/Relations! 19a. Informant's Name/Relations! 20a. Method of Disposition 1 Burial 2 XCremation 20a. Donation 5 Other Specified Status 21. Synature of Funeral Service	19b. Mailing Arry 1127 Place of Dispositic crematory or othe een Mou	Decedent of specify Colors (Sec. 2X) Usual Occupation of working Colors (Sec. 2X) Address (Sec. 2X) Address (Sec. 2X) Oldon (Name or place) Int Colors (Sec. 2X)	P. 221 If Hispan ban, Mosupation life. Do 18. If Each feet and	Mother's N Reche and Number ery, At Nat O	ame (Firse or Rural) or Rural	Yes or No- n, etc.) t, Middle, M Batc Route Numl Ve. e 9,20	White, etc. Specify: B1 16b. Kind of Busines n/a aiden Surname) chelor ber, City or Town, Sta Apt. A Ba 20c. Location - City	1 XYe puntry? erican Indian a C k s/Industry tte, Zip Code 1 to , M or Town, Stat	D.2122		
the death certificate be executed when the death certificate be executed with the attending physician and ched for use as the burial - transit Physician/Madical Evaminor	Cical Evallille		Due to (or as a d. AMENDED: AMENDED: AMENDED: AMENDED: Pegn	consequence of consequence of the consequence of th	me, g907, figuration of the seath of the sea	09/01, death	/201	Odhb		T Barratory arre	st, shock, or heart 23d. Date of delive Month	Betwee	Year
Division of Vital Records, P.O. Bo To the Hospital or Attending Physician: The law requires that the deat within 24 hours after death. To the Funeral Director: After this certificate has been signed by the at completely filled in by the funeral director, page 2 should be detached for	Colonication: 10 De completed by	3 Suicide 6 Could detent	Hospital: 1 28a. Date Aug 15, itigation I not be mined (Specify) yslcian: To the bes and manner so	npatient 2 void of Injury - At he coal Street of my knowled of examination a	ge, death occurre	26.P DOA Try 28c. 1 factory, offin d at the time n, in my opin	lace of Oth	Death (Cher4 Nut t Work? 2 No	1 28d. Subj	1 Yes 24a. Was all autops perform Yes 2 ne) me 5 F Describe helect shot cocation (Stor Town, State ast Chase of the cause of the	prior to death? 1 v tesidence 6 Othow injury occurred reet and Number or Fate) e Street, Baltimore (s) and manner as strind place, and due to 29d. Date signed (N	obably 4 autopsy finding completion Yes 2 er: Rural Route N , Md. ated. the cause(s)	Unknown ngs available of cause of No No
	;	/	who completed caus uty Chief Medic				C.M.E Baltim	-	21201		August 15, 201	0	
State Registra	-	31. Date filed (Month, Day, Year) AUG 1 7 2		gistrar's Signat	. box	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiens Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2010 Year Month **Physician** 3:45 P M 8 14 Maria Theresa Gilligan /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Longview Nursing Home Manchester Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day) **Funeral** Months Hours Days Min. 1 □ M 2 □X 87 225-26-7277 3-11-1923 VA Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show r than "natural", or items 23a or 28a-f shov the Medical Examinar must be notified at Carroll 1 ☐ Yes 2 X No MD Westminster Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21157 USA 11 Goni Terrace by Funeral 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc filed within 72 hours after 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 Specify: white 1 ☐ Yes 2 No Specify: 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Dental Office Secretary 12 or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 1 nent of Health and Mental Violet Anthony Laurence Phillips ျှ and l 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health at
Important: If Item 27 is
any injury or other trau 222 Park Dr., Westminster, MD 21157 M. Esther Muller-daughter Baltimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 8/19/10 Westminster, MD St. John Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fletcher Funeral Home 21. Signature of Funeral Service License homas D. Main St., Westminster, MD 21157 254 Ε. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respi shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 254 /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed burial-trai Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the ass IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy for Month Day Year 5 ☐ Other (specify) ☐Yes 2 No the detached 9 Unknown 9 Unknow signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ pe 1 ☐ Yes 2 🔼 No 3 ☐ Probably 4 ☐ Unknown completely filled in by the funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed?

1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death 24 hours after death Puneral Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 688 Poole Rd, Wistmin State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State Megistrar

State of Maryland / Department of Health and Mental Hygiene

23aPt1,25 per me,g906,08/16/2010dhb

Certificate of Death

Reg. No. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician/ 050 AM 2016 Medical 4a. Facility Name (if not institution, give street and number) 4b city, Town, or Location of Death 4c. County of Death **Examiner** N/A Bauviero Medical Center ionns Hopkins 8. Date of Birth (Month, Day, Year) Nov 28, 1943 Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 1 X M 2 □ F Months Days Min. Mary Land Hours 66 Director 212-42-0863 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 🗆 Yes 2 💢 No Maryland Baltimore Dunda1k 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 2023 Dineen Drive 21222 **USA** Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc. Yes 2 No þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: White 3 Divorced 4 Divorced Completed permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturenty injury or other traumatic event, the Medical once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 11College (1-4 or 5+) Designer Printing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Louis Hehring Sr. Marie Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2023 Dineen Drive Dundalk, Maryland 21222 Renora C. Hehring, Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1

Burial 2

Cremation 3

Removal from State Metro Crematory Inc. 08/06/10 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Spemation Society Of Maryland, Maryland 21228 21. Signature of Funeral Service Licensee Thomas Gregor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Intracerebra disease or condition resulting in death) da Medical Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions. Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last CERTIFIC Due to (or as a consequence of): signed by the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death page 2 should be detached 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed?
Yes 2 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 1100 ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Investigation 2 Accident 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Medical ✓ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number Res-000 namerine romas 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD 21224

Registrar

DHMH 17 Rev 7/2009

State

Katherine P.

31. Date filed (Month, Day, Year)

AUG 16201

Thomas MD

32. Registrar's Signature

4940 Eastern Aue

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** AUGUST 2010 8:50 A M JOYCE V. HAYNIE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/ABALTIMORE 329 S. NEWKIRK ST If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 M 2 F NOV. 83 9,1926 220-24-6761 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 28a-f show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD N/ABALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21224 USA 329. S. NEWKIRK ST Funeral 14. Bace - American Indian. Black, White, etc. WHITE Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) WESTERN UNION TELEPHONE OPERATOR permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygier Important: If Item 27 Is marked other the any injury or other traumatic event, the once. marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be VALLIE VIRGINIA COOK IRA PHILIP MOATS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 999 RED BANK RD. MIFFLINBURG, PA 17844 LINDA ESTUPINAN-SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 💢 Burial 2 ☐ Cremation 3 ☐ Removal from State 8/18/10 ELKRIDGE, MD MEADOWRIDGE MEM. PARK 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC 21. Signature of Funeral Service Licens 6224 EASTERN AVE BALTIMORE, MD 21224 Part 1. Enter the disease, or cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. It is any one cause on each line. Approximate Interval Between Onset and Death 23a, Part1 Immediate Cause (Final disease or condition **Physician** 0 disease or condition resulting in death) /Medical Du to (r as a consequence of): **Examiner** Sequentially list conditions, Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ttending physician and or us as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 2□ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home Hospital: 1 ☐ Yes 2 ☐ ER/Outpatient 3 ☐ DOA ို 1 Inpatient Residence 6 Other (Specify) 27. Manner of Aath 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification:

the death contificate be executed Box 68760, P.O. Division or Vital Records, After this funeral or Attending hours after death.

Baltimore, Maryland 21215-0036

Natural 5 Pending investigation ∠ □ Accident 3 ☐ Suicide 4 Homicide

6 ☐ Could not be

Injury 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29b. Signature and title of certifier

W and address of person who completed cause eath (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

W2120

STREET

filed (Month, Day, Year)

State Registrar DHMH 17 Rev 1/2001

within 24 hours a Hospital

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#1perPHYS, G906, 8/17/2010, WS
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician/ Henson 11:11p M John Henson 2010 Medical tuanst 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Season's Hospice Randallstown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Months Days Hours Min. 04 04 **Director** 222-07-8891 91 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Owings Mills MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21117 U.S.A. 9662 Devednte Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedon Armed Forces? 1 ▼Yes 2 □ No 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 XYes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3X Widowed 4 □ Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natul any injury or other traumatic event, the Medical Jonce. 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) US Postal Service Clerk <u>12th grade</u> 4yrs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lelia Lane <u>Soloman Henson</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Devednte Drive, Owings Mills, Md 21117 9662 <u>Terri Henson-Daughter</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet 8/18/10 Owings Mills, Md 22. Name and Address of Facility March F/H West 4300 Wabash Av of Funeral Service License Baltimore, Md 21215 Ave, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ a End-Stage Cardiomyopally disease or condition Medical resulting in death) Due to (or a consequence of): Examiner Seque tially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events iner Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and ned for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Dav Pregnant at time of death Year Yes 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown this certificate has been signed by the ral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 🗆 No Yes 2 No 1 Yes Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Hospital: ြု 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred eral Director: After filled in by the funer 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral I completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Definition in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20057465 8/11/10 MSKAJAPANIEM D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD. 21209. N.S. Ray a Pakte, M.D 28355mith AV-5-203 State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 2010 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2010 Month **Physician** 3:33 AM Ward /Medical a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** The Johns Hopkins Hospital Baltimore City If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1X M 2 F 7. Age (In yrs. last birthday) **Funeral** Days Hours 5-24-1942 68 Yrs PA Director 179-34-4078 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any fining or other traumatic pure. 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 👿 No Director Dauphin Hummelstown PA 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? United States 17036 10 Stoudt Rd. Funeral Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XXNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates Specify. Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) 12 years College (1-4 or 5+) Concession Sales Self Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Florence Taylor Edward R. Hoffman, Sr. ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 Stoudt Rd. Hummelstown, PA 17036 Claire Marie Hoffman (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Hoover F.H. & Crematory 8-18-2010 Harrisburg, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune al Service Licensee 22. Name and Address of Facility Eline Funeral Home 11824 Reisterstown Rd. Reisterstown, MD 21136 J. Wayne Osterling Approximate Interval Between Onset and Death se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hea Immediate Cause (Final disease or condition resulting in death) Physician emoptusts /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician an Division of Vital Records, P.O. Box 68760, Physician/Medical ası attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) d by the al Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Minpatient Other: 4 Nursing Home 5 Residence 1 Yes 2 No 2 ER/Outpatient 3 DOA 6 Other (Specify) မ this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation (Month, Day Year) Injury 1 X Natural 1 Yes 2 No 2 Accident after death.

Director: A d in by the fu 3 🗌 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours aft

To the Funeral Dil

completely filled ir 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

Barbara Hei 6 MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

29d. Date signed (Month, Day, Year)

ORIGINAL

29c. License number

RES-000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

_ewis Hypolite		1- For State	Sta	ite of Maryla				nd Ment	al Hygier	ne -	20	10	2553
Physicia		Registrar 1. Decedent's Name (First Middle	Last)	Cer	tificate o	Deam		2 Dat	Re e of Death	3		2 J J J 3. Time of Death
Medical Exami				,					Mor		Day Year	,	1807 hrs
		4a. Facility Name (if r	not institution	, give street and nu	mber)		4b. City, Town, c	or Location of		, uot 0, 2	4c. County of	Death	
		3 North Highl	and Aven	ue			Baltimore						
Funeral		5. Social Security Nur	mber 6	6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Ye			ate of Birtl	h (MM/DD/YYYY)	9. Birth oreign	
Director		213-84-37	14	1 X M 2 F 49 Yrs			Months Da	ys Hours	Min. MA	Y 23	, 1961	Cour	^{ntry)} NY
,		Usual Residence of D									· · · · · · · · · · · · · · · · · · ·		
w an		10a. State	b. County		10c. City,	Town or Locat	ion						10d. Inside City Limits
yland P-f she	힑	MD 10e, Street and Numb			BA	LTIMORI						1 XYes 2 No	
te Maryland or 28a-f show any fied at once.	Director	Toe. Street and Numb	er				10f. Zip Code			10	g. Citizen of Wha	Countr	у?
ith the		3 N. HIGH	LAND A			- L.o	21224				USĄ		
ath w	Funeral	1 Never Married	2 Mar	ried Armed Fo		S. 13. Wa	s Decedent of H es, specify Cuba	ispanic Origir in, <mark>M</mark> exican, F	n? (Specify Your Puerto Rican,	es or No- etc.)	14. Race - White,		an Indian, Black,
rer de		3 Widowed	4 Divor	1 Yes rced If Yes, Give Year	2 X No	1	Yes 2 X No	n specify:			Specify:	BLAC	יער
urs af tural amin	à	15. Decedent's Educ		or Dates:		16a. Deceden	t's Usual Occupa		nd of work dor	ne	16b. Kind of Busin		
72 ho	Completed	Elementary/Second		College (1		during m	ost of working life	e. DO NOT u	se retired)				,
5-0036 led within 7. tygiene. other than	립	12TH				MASO	NARY				CONST	RI ICT	PTON
21215-0036 uld be filed within 7 Mental Hygiene. marked other than		17. Father's Name (Fi	rst, Middle, L	ast)				18. Mother's	Name (First, I	Middle, M	aiden Surname)	. برک	
121 d be f lental arkec	Be	CARLTON H						SHIRI	EY L.	CUMM	INGS		
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Lant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	은	19a. Informant's Name				100					per, City or Town,	State, Z	(ip Code)
and 2 and 2 cealth tem 2 traum	ŀ	MARLENE JO 20a. Method of Dispos		STER	20b. P		HIGHLA tion (Name of ce		BAL Date	TIMO	RE MD 20c. Location - C	2122	
Baltimore, permit. Pages I an Department of Her Important: If ite injury or other training or other tr	-	1 Burial 2 X	Cremation	3 Removal fro		rematory or oth		,	54.0	- 1	zee. zeeddien o	ity or 10	own, orace
Baltimo permit. Page Department Important: injury or otl	-	4 Donation 5 21. Signature of Funer			//	ARDI	INT	0	8/17/2	010 l	HANOVER	<u>, MI</u>)
Balti permit. Departm Imports	Į	21. Signal of une	CHA	VIS, JR.	FNI								
Physician		23a. Part I. Enter the	isgase, or co	omplications the	used the death.	Do not enter th	e mode of dying	, such as car	N AVE. diac or respira	BA atory arres	LTIMORE,	MD	21231 Approximate Interval
/Medical		failure. List only Immediate Cause (Fin		200	horocole	rotic	Cardiova	000110	- Dico	000			Between Onset and Death
Examiner		or condition resulting i		Due to (or as a			Cararova	ascura	I DISE	ase		-	
		Sequentially list condi		b									
	in	if any, leading to imme cause. Enter Underly	ing Cause	Dua to (or as a	tonsequente of	i.							
=	Examine	(Disease or injury that events resulting in dea		Due to (or as a	consequence of):							
and	삙			d									
be e siciar	dical	x UNPENDED		AMENDED	23a,27	per me	g906 8-	-27-10	vt				
ox 6876(eath certificate attending phy.	Ĭ,	IF FEMALE: 23b. Was decedent pre	gnant in the		utcome of pregn						23d. Date of de		
Box 6876 death certificate the attending phy dof or use as the b	Ciar	past 12 months?		1 Live bi	nt at time of dea	th =	al death 3 er (Specify)	Ectopic p	regnancy		Month	Day	/ Year
BOy e death the att	Physician/M	1 Yes 2 No	9 Unkno	9 Unknow	v n	o Ou	lei (Opcony)						
P.O. that the ned by detache	by P	Part II. Other significa	ant condition	ns contributing to	death but not re	sulting in the u	nderlying cause	given in Part	1. 23	_	acco use contribu		
S, P.C.									_ [1	Yes	2 V No 3	Probab	ly 4 Unknown
ords, w requires been should	Completed								24	a. Was an autopsy			osy findings available apletion of cause of
Recc The lan	E								1	Perform		th? Yes	2 No
Vital Recypsician: The his certificate director, page	e B	25. Was case referred examiner?	to medical				26.Place		neck only one)			
Vit	<u> </u>	1 ✓ Yes 2	No	Hospital: 1 In		ER/Outpatient		Other ₄ N	lursing Home	5 R	esidence 6 🗸	Other: S	cene
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the safer death. To all Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacl		27. Manner of Death 1 X Natural 5			f Injury Day,Year)	28b. Time of In		ry at Work?	- 1	scribe ho	w injury occurred		
Siol Miten death ctor:	ξį	2 Accident	Pending Investig	gation				Yes 2 N					
Divis pital or At ours after d ceral Direct filled in by	Certification:	3 Suicide 6	Could r	lot be	of Injury - At hor	ne, farm, stree	, factory, office b	building, etc.		ation (Str Town, Sta		r Rural	Route Number, City
Divis Hospital or A 24 hours after Funeral Dire		4 Homicide 29a. Certifier		(Opacity)					111				
Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b				sician: To the best ner:On the basis of	examination and								ause(s)
To Con	ĕŀ	29b. Sigivature and title		and manner sta	ited.		29c. Licens				29d. Date signed		
		// K.	00	$A \cap A$			O.C.I	M.E.			August 9, 201		
	H	30. Name and address	of person wh	no completed cause	of death (Item 2	23a)							
		Laron Locke M		istant Medical	Examiner	111 Penn	Street, Baltir	nore, MD	21201				
		31. Date filed (Month, D			istrar's Signature	Book	1						
Registr	ell	AUG	17 201	U Ball	A 19.	Section of Management							

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 20 10 25537 State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate C	of Death	Reg. No.
Physici	ian/	Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death 3. Time of Death
dical Exam				Month Day Year 1605 hrs
		Gayle Carrolline Heid 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deal	
		Washington Adventist Hospital	Takoma Park	Montgomery
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hr Months Davs Hours Mi	Foreign
Director		228-74-9653 1 M 2XF 60 Y	rs. Months Days Hours Mi	April 5,1950 Country VA
		Usual Residence of Decedent		110111 3/1330
iny		10a. State 10b. County 10c. City, Town or Local	ation	10d. Inside City Limits
A 0 41				1 X Yes 2 No
Maryland 28a-f show any 1 at once,	rector	VA Arlington Vienna		
Mary 28a dat	မို	10e, Street and Number	10f. Zip Code	10g. Citizen of What Country?
ith the Maryland 23a or 28a-f sho notified at once.	ᄒ	2626 Chain Bridge Road	22181	USA
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiesh Arrian 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	ū	11. Marital Status 12. Was Decedent Ever in U.S. 13. W	/as Decedent of Hispanic Origin? (S	Specify Yes or No- 14. Race - American Indian, Black,
eath iten	Funera		Yes, specify Cuban, Mexican, Puert	o Rican, etc.) White, etc.
er de		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	Yes 2 No specify:	specinWhite
s aft iral'	و	or Dates:		
hour natu Exar	ompleted	during	ent's Usual Occupation (Give kind of most of working life. DO NOT use re	
36 hin 72 te. than "	<u>ē</u>	Elementary/Secondary (0-12) College (1-4 or 5+)		
O3	Ę	12	Housewife	Private
5-0 ed w other	ပိ	17. Father's Name (First, Middle, Last)	18.Mother's Nam	e (First, Middle, Maiden Surname)
21215-0036 uld be filed within 72 hours afte Mantal Hygies marked other than "natural", e event, the Medical Examiner	Be	William Scott	Edith	Rutherford
21 uld b Mer mar	2		ng Address (Street and Number or	Rural Route Number, City or Town, State, Zip Code)
MD d 2 sho lth and n 27 is	_	Cathlena Heid 3928	25th Ave Te	emple Hills, MD 20748
, N and 2 ealth ean 2 raun			osition (Name of cemetery,	Date 20c. Location - City or Town, State
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed with pagement. Pages I and 2 should be filed with Important: If item 27 is marked other It injury or other traumatic event, the Med		1 Burial 2 X Cremation 3 Removal from State crematory or c		200. Eddallott - Oity of Town, otate
Page ent cent			ake Crem. Auc	4 2010 Beltsville, MD
orts o		21. Signature of Funeral Service Licensee 22.	Name and Address of Facility Au	4,2010 Beltsville, MD stin Royster Funeral Home
In The Dep		MOOGEO MOOGEO		
4 Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter	821 14th St. N	W. Washington, DC 20011 or respiratory arrest, shock, or heart Approximate Interval
~ Physician Wedical		failure. List only one cause on each line.	the mode of dying, sacri as carales	Between Onset and
Examiner		Immediate Cause (Final disease a. Head Injuries		Death
		or condition resulting in death) Due to (or as a consequence of):		
		Sequentially list conditions, b.		
	Je.	if any, leading to immediate Due to (or as a consequence of):		
	miner	cause. Enter Underlying Cause (Disease or injury that initiated c.		
sit d	Exa	events resulting in death) Last Due to (or as a consequence of):		100
cute and tran		d		
760, icate be executed physician and the burial - trans	/Medical	■ UNPENDED	28a-f per me g908	8 10–15–10 vt
760, icate be ex physician the burial	Nec	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery
	_	23b. Was decedent pregnant in the	etal death 3 Ectopic pregn	ancy Month Day Year
Box 68' death certificate at the attending at for use as	siciar	Page 12 110111101	Other (Specify)	
Soy leaft for	ysi	1 Yes 2 No 9 V Unknown 9 Unknown	, the table of the table of the table of table o	
O. B. In the de by the	Phys	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
rres that is signed by the detaction	by		3	1 Yes 2 No 3 Probably 4 V Unknown
D. S. D. L. Sig	þe	Chronic Alcohol Abuse	 	
Records, The law require	Completed			24a. Was an 24b. Were autopsy findings available prior to completion of cause of
CO e law e 2 s	ם			performed? death?
Reat Thy Bag	ပ္ပ			1 ✓ Yes 2 No 1 ✓ Yes 2 No
tal Recian: The certificate ector, page	Be	25. Was case referred to medical examiner?	26.Place of Death (Check	only one)
Vital hysician: this certi	0	examiner? 1 ✓ Yes 2 No Hospital: 1 ✓ Inpatient 2 ER/Outpatier	nt 3 DOA Other: Nursi	ng Home 5 Residence 6 Other:
ing Pl	<u>:</u>	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of	Injury 28c. Injury at Work?	28d. Describe how injury occurred
E ii	Ö	Natural 5 Pending Fd 7-20-10 unknown	1 Yes 2 X No	auldock 6-11
Sic Afte ecto	Sa	2 X Accident Investigation 28e. Place of Injury - At home, farm, str		subject fell 28f. Location (Street and Number or Rural Route Number, City
Division of Vital Records, P.O. Box 68 Hospital or Attending Physician: The law requires that the death certifued and after death. Remeral Director: After this certificate has been signed by the attending tely filled in by the funeral director, page 2 should be detached for use as	ertification:	Suicide Could not be	soc, ractory, office building, etc.	or Town, State) 1820 University Blvd. Hyattsville, Md. 20783
Dispital nours a neral liftled	Cer	4 Homicide		Hyattsville, Md. 20783
Hos 24 h Fur	<u>ia</u>	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurrence of the control of the cont		
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical	one) 2 Medical Examiner: On the basis of examination and/or investigation	ation, in my opinion, death occurred	at the time, date and place, and due to the cause(s)
To To	Me	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	_	/ / / / / / / / / / / / / / / / / / / /	O.C.M.E.	July 24, 2010
9.		alle	J.O.IVI.E.	July 24, 2010
gant		30. Name and address of person who completed cause of death (Item 23.1)		
9		Zabiullah Ali, M.D. Assistant Medical Examiner 111 Pe	nn Street, Baltimore, MD 21	1201
	ate	31. Date filed (Month, Day Year) 32. Registrar's Signature		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10b&state of Maryland 996 partment of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ $\overset{\mathsf{Month}}{\mathsf{Julv}}$ 2010 8:35 РМ <u>Philip Ignatius Heuisler III</u> Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Baltimore Towson Gilchrist Hospice Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1**X** M 2 □ F Months Days Hours Min. Oct 28, Year 1936 Mary Tand Director 216-34-9555 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be another than any injury or other traumatic event, the Medical Examinar must be another and 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Baltimore 1 Yes 2XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6102 Buckingham Manor Drive 21210 USA 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Year or Dates Completed 3 🗆 Widowed 4 🗆 Divorced Specify 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry un(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Elizabeth Irene Kelly Philip Ignatius Heuisler Jr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6102 Buckingham Manor Drive; Baltimore, MD 21210 Ann Heuisler - wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) ☐ Burial 2 ☐ Cremation_3 ☐ Removal from State 4 Donation 5 Other (Specify) Signature of Euperal Services licer 22. Name and Address of Facility State Anatomy Board Wane 655 W. Baltimore Street; Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ DIVOTION disease or condif Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ rial tibrilation, ma) Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an this certificate has autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) 1 🗌 Yes 2 XNo Other: ည 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence HOSOICE funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28b. Time of within 24 hours after death.

To the Funeral Director: After 28d. Describe how injury occurred 1 Natural injury 5 Pending Investigation 6 Could not be 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number. Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year, Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State AUG 17201 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 3:45 20**1**0 Рм Barbara Rae Holmes Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Joseph Richie Hospice If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🖺 F Sept 15, Year) 1948 Montana Yrs. Director 61 517**-**58**-**3784 Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland Director MD Baltimore 1 ☐ Yes 2 1 No 10g. Citizen of What Country? USA 10f. Zip Code 21228 10e. Street and Number 205 Brookside Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black White etc þ 1 Never Married 2 Married Maryland 21215-0036 white 1 ☐ Yes 2 No Specify: Yes, 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) own home homemaker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Muriel Irene Wilson George Arthur Gabisch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, William Holmes - husband 205 Brookside Drive; Baltimore, Maryland 21228 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Signature of Firmal Service Live Service Liv 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore Street; Baltimore, MD 21201 Hart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ years disease or condition Medical resulting in death) Mellitus - Type II Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine sician and burial-transit Due to (or as a consequence of): attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be exiting to both charts after death.

To the Funeral Director, After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the bur IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown Division of Vital Records, 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death? 1 Yes 2 No 1 🗍 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) 12. 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury (Month, Day, Year) 1 Natural 2 Accident 5 Pending 1 Yes 2 No М Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title certific

State Registrar 31. Date filed (Month, Day, Year)

AUG 172010

8

Holmes

828 North Eutaw Street, Bactimon, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

august 11, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Month 08 2. Date of Death Physician/ Hepburn 1400 P M Dehorah Ann Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 7811 Stafford Hill Court Glen Burnie Anne Arundel Social Security Numb Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month Months Days Hours Min Country)
Maryland Director Usual Residence of Decedent shov 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 7811 Stafford Hill Court 21061 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. 2 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: White 3 - Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Contract Specialist Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ralph Amaryllis Normalee Simons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glen Burnie, MD 21061 Mrs. Darlene M. Pahl / Sister 7811 Stafford Hill Court 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1XX Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Park 08/19/2010 Elkridge, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility Singleton Funeral & Cremation Services PA; 1 2nd Ave SW, Glen Burnie, MD 21061 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) consequence of Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transil that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death signed by the a d be detached f 1 Yes 2 g 2 🗌 No Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 2 should Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 1 🗌 Yes 2 🗌 No 1 🗌 Yes 🔑 25. Was case referred to nedical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital Other: ျှ 1 Tes 2 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home After this 28a. Date of injury (Month, Day, Year) Manne 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Plao At home rm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined etc. (Specify) Medical Certifying Physician: To the be 29a. Certifier death occured at the time, date and place, and due to the cause(s) and manner as stated. owledge сотретер (Check Medical Examiner: On the basis or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: rledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. hin 2 only one) 29b. Signature and title of certifie 29c. Licer epleted cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25541 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August Samuel 1721 Albert Houseman 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Howard County General Columbia Howard Hospital 5. Social Security Number 6. Sex. 1 M 2 □ F If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last hirthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days March 025 1946 MaryTand Director 214-44-4997 64 Yrs. Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🗓 No MD. Elkridge Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 21075 United States 6315 Virginia Pine Place 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Black, White, etc. "natural", or þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore Gas permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any Injury or other traumatic event, the Mo Elementary/Seconday (0-12) College (1-4 or 5+) Electric Lineman 10th N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Edith Homes UNK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6315 Virginia Pine Place ,Elkridge,Maryland 21075 <u>V. Houseman / Wife</u> Carol 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place)
Meadowridge Mem. Park Aug. 14,2010 Elkridge, Maryland 4 Donation 5 Other (Specify) Signature of Emeral Service Licenses 22. Name and Address of Facility AMBROSE FUNERAL HOME, INC. 1328 Sulphur Spring RD., Arbutus, Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Coronary Onset and Death Vessel Disease Hherosclerotic Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events physician and is the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Pregnant at time of death Yes 2 □ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 No 2 🗌 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: မ 1 Yes 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 2 ☐ Accider 3 ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🗲 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 To the 29c, License number D 0 0 5 3 3 1 2 29b. Signature and title of certifie MO

DHMH 17 Rev 7/2009

State Registrar Cedar Cone, Columbia, MO 21044

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michelle Henggeler, MD 5753

31. Date filed (Month, Day,-Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 2 per doc g906 8-24-10 vt
State of Maryland 7 Department of Health and Mental Hygiene For State Registrar Reg. No. 2 N Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 12 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death WarwickExaminer 4c. County of Death 3 Cecilton Manor Drive Cecil Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 06/12/ 7. Age (In vrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Months Days Hours Min 040-30-2999 1 M 2 XF 72 Director Yrs 2/1938 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show important: if item 27 is marked other than "natural", or items 23a or 28a-f show important: if item 27 is marked other than "natural", and injury or other traumatic event, the Medical Examiner must be notified at anno. 10b. County 10a, State 10c. City. Town or Location Director 10d. Inside City Limits Warwick MD Cecil 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral Cecilton Manor Drive 21912 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black, White, etc. 9 1 Never Married 2 Married 1 Yes 2 No
If Yes, Give
Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Property Manager Housing 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Evelyn Foust 2 Wilbur Hallock 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3 Cecilton Manor Drive, Warwick, MD 19a. Informant's Name/Relationship (Type, Print) 21912 Wayne A. Schrager/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 \square Burial 2 $\raisebox{.5ex}{$\stackrel{\frown}{\boxtimes}$}$ Cremation 3 \square Removal from State 8/17/2010 4 Donation 5 Other (Specify) Final Journey Crem. Woodbine, MD Signature of Funeral Service Licensee Dorota Marshal ^{22. Name and Address of Facility} Cremation Services
PO Box 1413, Baltimore, MD al 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): attending physician and for use as the hurial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death the Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 **X**Wo Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) After this funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Watural work? 5 Pending injury n 24 hours after death.

The Funeral Director: Af oldered filled in by the fundamental filled in the fundamental filled fundamenta Accident Suicide 2 🗆 No Investigation
Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical 1 Medical Examiner: On the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check within 2. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number ed cause of death (Item 23a) (Type,

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year,

			For State Registrar		State o	of Maryla	nd / Depa	artment of I	Health Death	and M	lental Hy	giene	201	0	25543
	D		Decedent's Name	(First, Middle				tinoato or i	Journ		2. Date of Dea	ath			3. Time of Death
	Physicia Medi	cal	Je			nedy					Month Augus	t $\overset{Day}{1}$., ž	010	7:40 A M
	Examir	er	4a. Facility Name (if r		give street and nurr ted Livin	,	or	4b. City, Town, or Gaithe				4c. County of Death Montgome			
R	Funeral	÷	5. Social Security Nu		6. Sex		. last birthday)	If Under 1 Year	If Under	24 Hrs.	8. Date of Birt	 :h			ace (State or Foreign
	Director		577-40-7		1 □ M 2 X] F	8	1 Yrs.	Months Days	Hours	Min.	April Day	th Day Year) 1929 Was			
	ind show	5	Usual Residence of E 10a. State	10b. County		10c. (City, Town or Lo	cation						10	d. Inside City Limits
	Maryland 28a-f show otified at	rect	MD	Ho	vard			Glenwo	ood						1 ☐ Yes 2X No
	n the la or 2 be no	ا قا	10e. Street and Numi	ber				10f. Zip Code			T	10g. Citize	en of Wh	at Counti	y?
	s after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at	Funeral Director	4020 Ro	xmill		bare 1.1	la lasi		1738				nite		
ယ	er dea or ite niner	y F.	 Marital Status Never Marrie 	d 2 Marri	12. Was Dece Armed For 1 \sum Yes	rces?		Vas Decedent of H f Yes, specify Cuba	ispanic Ori ın, Mexicar	igin? (Spein, Puerto F	cify Yes or No- Rican, etc.)	14	4. Race - Black,	America White, et	
Š	ırs aft ural", ILEXAL	Completed by	3 Widowed 4	X Divorced	If Yes, Giv Year or Da	e **	1	☐ Yes 2 🔀 No	Specify:	:		Sp	pecify:	Whi	te
15-	72 hou n "nat ledica	nple	(Spec	15. Deceden ify only highes	's Education t grade completed)		(Give I	lent's Usual Occup	during mos	t of workir	ng	16b. Kind	d of Busin	ness Indu	stry
212	vithin jiene. er thai		Elementary/Secon	nday (0-12)	College (1-	4 or 5+)	life. Do	O NOT use retired)							
P	filed tal Hyg d oth		17. Father's Name (Fi								(First, Middle,	Maiden Su	ımame)	-	
₹	uld be d Men marke natic	욘	John	W.	Shu	ltz				dith				gson	
Maryland 21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Nan Susan K.		n <i>(Type, Print)</i> an / Daug]	hter		g Address <i>(Street a</i> Tanyard							^{de)} 20879
Jre,	of Hee		20a. Method of Dispo				Place of Dispos				ate	20c. Loca			
Baltimore,	. Page trment tant: It		1 □ Burial 2 □ 4 □ Donation 5		3 Removal from pecify)	State Ch	esapeak	e Cremato	ry		3,2010		1tsv	ille	, MD
Ball	permit. Page 1 and 2 Department of Healt Important. If item 2 any injury or other 1		21. Signature of Fund	eral Service bi	ensee	Moos	82 R	Name and Address app Funer 33 Gist A	ss of Facilit	nd Cr	emation	Ser	v <u>i</u> ce	Sano	10
			23a. Part 1. Enter the	e disease, or o	omplications that c	aused the dea	ath. Do not ente	r the mode of dying	g, such as	cardiac or	respiratory arm	est,	rib		Approximate
	Ph_sician/		Immediate Cause (Fi disease or condition		ly one cause on each		ailure :	to Thrive	3						nterval Between Onset and Death e Week
9	Medical Examiner		resulting in death)	- (or as a conse									e week
		Jer	Sequentially list conditions if any, leading to imm	ditions.	D	ementi. or as a conse								-	
	uted nd ransit	ami	if any, leading to imm cause. Enter Underly Cause (Disease or iin that initiated events	ring njury	с		. ,								
	ate be executed ohysician and the burial-transit	edical Examiner	resulting in death) La	st	Due to (d	or as a conse	quence of);								
760	eath certificate be ex attending physician for use as the burial				d	_								+	
Box 687	certifi anding use as	N N	F FEMALE: 23b. Was decedent pi		23c. If yes, outo	ome of pregr	ancy					230	d. Date o	f deliven	
Box	death he atte ed for	Completed by Physician/M	in the past 12 mo 1 ☐ Yes 2 🌠 9 ☐ Unknown			ant at time of	death 5	Ectopic pregnance Other (specify)	У				Month		ay Year
P.O.	requires that the de been signed by the s should be detached	된	Part II. Other signific	ant condition	L		sulting in the ur	nderlying cause give	en in Part I		23e Did to	hacco use	contribu	te to the	cause of death?
	ires the signer of the contract of the contrac	d b			s, Gait										oly 4 🗆 Unknown
ord	w requ	plet	Hyperte	ension,	Hyperli	pidemia	a.				24a. Was a		24b. Wer	e autops	y findings available
Records,	The law ate has page 2:	E O									autops perfor 1 \sum Yes	med?	deat	r to comp th? Yes 2	bletion of cause of
	ding Physician; The le h. After this certificate ha funeral director, page	a l	25. Was case referred examiner?		Hospital:				ice of Deat	h (Check					
of Vital	Phys rathis rathir	<u>و</u>	1 Yes 2 7. Manner of Death	No	1 🗆 I		ER/Outpatient	3 DOA Othe	4 ∟ Nu					Specify <u>)</u> A	sst. Livin
ou c	nding ath. r: After e fune	icate	マアマア	5 Pending	(Month	n, Day, Year)	injury	work	Yes 2		Bd. Describe ho	w injury o	curred		
Division	r Atte	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could no determin	ad 28e. Place of	of Injury - At h g, etc. (Specii	ome, farm, stree v)	et, factory, office		2	8f. Location (St City or Town		lumber o	r Rural Re	oute Number,
Ō	Hospital or Attending Physician; The law requires that the death certific 24 hours after death. Funeral Director: After this certificate has been signed by the attending is ated filled in by the funeral director, page 2 should be detached for use as	sal c	29a. Certifier 1 🖸	Cartifuing	hysician: To the be			acurad at the time	data and r	3					
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: At completed filled in by the fu	Medical	(Check 2 ∟	J Medical Ex	aminer: On the basis lurse Practioner: To	s of examination	on and/or investi	aation, in my opinior	n, death oc	curred at t	he time date an	diplace an	of due to	the cause	e(s) and manner stated. d.
	To t	2	9b. Signature and titl	e of certifier Lucer	there	chb.	· Jun	29c. License	number	5		9d. Date s 4ccq	_		, Year) , 2010
0		3	0. Name and address H. Robert	s of person wi	o completed cause	of death (Iter	n 23 a) (Type, Pr		Gaitl	hersb			877	,	
	Stat		1. Date filed (Month,	Day, Year)		gistrar's Signa	ature	-			<i>.</i>				
DUI	Registra		AUG 172	110 /	many &	9. ADA	Wall .								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Edward Chin Kim 08/14/2010 11:39A^M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Casey House Rockville Montgomery Social Security Number 7. Age (In yrs. last birthday)
70 yrs. If Under 1 Year If Under 24 Hrs 6. Sex Birthpia. Country) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days 1 **X**M 2 □ F Months 578-90-4499 Min. (Month, Day, Year) 12/25/1939 Hours **Director** Korea Usual Residence of Deceden filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits or 28a-f s notified Burtonsville MD Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code ms 23a or must be n 10g. Citizen of What Country? Funeral 14608 Friendlywood Rd. 20866 United States er than "natural", or items the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: Year or Dates Asian 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) If Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Entrepreneur Retail alth and Mental Hygie 27 is marked other r traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve once. မ Don Jun Kim Jun Ik Chang 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12900 Shaw P1. Silver Spring MD 20904 In Chung Kim 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗶 Cremation 3 🗆 Removal from State T, 12010 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Beltsville, MD Signature of Funeral Service 933 Gist Ave. 20910 22. Name and Address of Facility Rapp Funeral & Cremation Ser. Silver Spring MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Cerebral Vascular Accident disease or condition) Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events attending physician and I for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death Day Year Yes 2 No signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by cate has been sig page 2 should b Completed Chronic Renal Disease 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Hepatitis C 24a. Was an autopsy performe this certificate 2 🗌 No Yes 2 No 1 Yes director, 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes 2 🗌 No Other: 1 Inpatient 2 I ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗙 Other (Specify) HOSPSCc 27. Manner of Death 28a. Date of injury (Month, Day, Year) After t 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work?
1 Yes 2 No 5 Pending injury neral Director: A Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hor To the Fune completed fi (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certi 29d. Date signed (Month, Day, Year, 1112108 08/14/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year,

32. Registrar's

MD 20855

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 09:05 AM William Daniel Keim Sr. August (2 2010 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Baltimore Sant Hospital Agues If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Months 1 X M 2 □ F 217-26-6421 90 May 9, Maryland Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location Baltimore 1 ☐ Yes 2 ☐ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2109 Arlonne Drive 21228 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1XYes 2 No 1943-1 ☐ Never Married 2 1 Married

(Give kind of work done during most of working life. DO NOT use retired) customer

Specify: white

16b. Kind of Business/Industry

18. Mother's Name (First, Middle, Maiden Surname)

2109 Arlonne Drive; Baltimore, Maryland 21228

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

22. Name and Address of Facility State Anatomy Board

Mary Francis McDonough

655 W. Baltimore Street; Baltimore, MD 21201

24a. Was an

1 ☐ Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Manyland

26. Place of Death (Check only one)

autopsy performed? Yes 2 No

28d. Describe how injury occurred

TBM

20c. Location - City or Town, State

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▼No

2010

Month

23e. Did tobacco use contribute to the cause of death?

28f. Location (Street and Number or Rural Route Number, City or Town, State)

August, 12

29d. Date signed (Month, Day, Year)

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

8 days

Year

1 ☐ Yes 2 🖾 No

service representative

16a. Decedent's Usual Occupation

20b. Place of Disposition (Name of cemetery, crematory or other place)

1946

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line.

GHERRYSH

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

900

2. Registrar's Signature

28b. Time of Injury

myocardia

3 Ectopic pregnancy

28c. Injury at Work?

1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 ☐ Yes 2 ☐ No

Baltimore

5 Other (specify)

Due to (or as a consequence of):

Due to (or as a consequence of)

Due to (or as a consequence of)

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

diseas.

28a. Date of Injury (Month, Day, Year)

9 Unknown

Coronary artery disease

Hospital:

In nothin Wang, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wang

Ceremovascular

5 Pending investigation

Could not be determined

Year or Dates:

College (1-4or 5+)

Physician /Medical Examiner

Examiner

Physician/Medical

þ

Completed

Be

Certification: To

Medical

State Registrar

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 is marked other any Injury or other traumatic event.

Physician

Examiner

Funeral

Director

show

ortant; If item 27 is marked other than "natural", or items 23a or 28a-1 sho Injury or other traumatic event, the Medical Examinar must be notified at

filed within 72 hours after death with Hygiene.

Baltimore, Maryland 21215-0036

/Medical

10a. State

Director

Funeral

Š

Completed

MD

11. Marital Status

3 Widowed 4 Divorced

Elementary/Secondary (0-12) 12

20a. Method of Disposition

Immediate Cause (Final

5 questially ist outlities if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant in the past 12 months?

9 Unknown

□Yes 2□No

25. Was case referred to medical examiner?

1∐Yes 2XNo

27. Manner of Death

1 Natural 2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

Ming Hsi

31. Date filed (Month, Day,

disease or condition resulting in death)

IF FEMALE:

17. Father's Name (First, Middle, Last)

Julius Daniel Keim 19a. Informant's Name/Relationship (Type. Print)

Doris Keim - wife

4 X Donation _5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Konald S Wade,

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

15. Decedent's Education (Specify only highest grade completed)

attending physician and for use as the burial-transit After this certificate has been signed by the attendir funeral director, page 2 should be detached for use

After this

death.

24 hours after death Funeral Director: filled in by the

within 2

Vital Records, P.O. Box 68760, eim, William Division of Hospital or Attending

			For State Registrar	State of Ma	ryland		artment tificate			and M	lental Hy	gien Reg. N	2010	25546	
	Physicia		1. Decedent's Name (First, Middle, Li Elizabeth King	ast)				_			2. Date of De Month August	ath		3. Time of Death 3:00 A M	
	Medic Examin		4a. Facility Name (if not institution, given Riderwood Villa		Home		4b. City, T		Location o		August		c. County of Dea	ath	
	Funeral Director		Social Security Number 6.		(In yrs. last	birthday) Yrs.	If Under		_	24 Hrs.	8. Date of Bir (Month, Da Dec 5,	th 19, Year)	9. Bi	inthplace (State or Foreign ountry) Va Scotia	
	/land f show ed at	tor	Usual Residence of Decedent 10a. State 10b. County MD Monts			Town or Loc								10d. Inside City Limits	
:	n the Mar a or 28a- be notifie	al Director	10e. Street and Number	gomery	51	lver	10f. Zip (Code			T		itizen of What C	1 Ves 2 No	
:	death with items 23 per must	Funeral	3160 Gracefield	12. Was Decedent Eve Armed Forces?	er in U.S.	13. V		904 ent of His	panic Orig	in? (Spec	cify Yes or No- Rican, etc.)		USA 14. Race - American Indian,		
9003	ours after of tural", or al Examir	ted by	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates.		1	☐ Yes 2	⊠ No	Specify:	, ruerto r	nican, etc.)		Black, Whi	hite	
Baltimore, Maryland 21215-0036	I and z should be filed within /z hours after death with the Maryland if Health and Mental Hygiene. **Health and Mental Hygiene. **The marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's (Specify only highest g			life. DC	ent's Usual ind of work NOT use i Lentis	done du etired)	tion Iring most	of workir	og		researc	-	
yland	Id be riled a Mental Hyg arked oth atic event	To Be	17. Father's Name (First, Middle, Last) Harold Skinner			-					(First, Middle, aymond	Maiden	Surname)		
, Mar	nd 2 shou ealth and m 27 is m ier traum		19a. Informant's Name/Relationship (Charles Reynes										r Town, State, Z Valley	ip Code) , CA 94552	
timore	permit. Page 1 a Department of H Important: If ite any injury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 [4 ☒ Donation 5 ☐ Other (Spec	Removal from State		ce of Dispos netery, crem	atory or oth	er place,			ate		ocation - City o	r Town, State	
Ball	Depart Depart Impor any in		21. Signature of translating relation	Well			655 W	I. Ва	altim	ore		Ва		, MD 21210	
√PI	nysician/		23a. Part 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition	nplications that caused the cause on each line. severe cl										Approximate Interval Between Onset and Death Years	
E	Medical Examiner	<u>.</u>	resulting in death) Sequentially list conditions.	Due to (or as a c	tial	lung	disea	se						years	
Cuted	and	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events	c. Due to (or as a c											
oU ate he ex	physician the burial	dical	resulting in death) Last	d	onsequen										
. Box b8/c	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live Birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	☐ Fetal de	eath 3 🔲	Ectopic pro						23d. Date of de Month	elivery Day Year	
S. that the	signed by	<u>م</u>	Part II. Other significant conditions of atrial fibrillat:						n in Part I.					o the cause of death?	
Mecords, The law requires	has been je 2 shoul	Completed			-						24a. Was a	an osv	24b. Were au	itopsy findings available completion of cause of	
VITAI M	sertificate ector, pag	å	25. Was case referred to medical examiner?	Hospital:				1	e of Death	(Check	performance 1 \(\text{Yes} \)	2 X N	o 1 🗆 Ye	s 2 🗆 No	
I OI V	After this (funeral dir	ate: To	1 ☐ Yes 2 ☒ No 27. Manner of Death 1 ☒ Natural 5 ☐ Pending	1 ☐ Inpatient 28a. Date of injury (Month, Day, Y	28	Outpatient b. Time of injury	280	. Injury a work?	ıt	28	ne _5		Other (Special of the Control of the	cify)	
IVISION or Attendir	after death Director: /	Certificate:	2 Accident Investigatio 3 Suicide 6 Could not to 4 Homicide determined	e 290 Pleas of Injuny		, farm, stree	M et, factory, o		es 2□1 -		8f. Location (S City or Tow			ral Route Number,	
U e Hospita	e Funeral	Medical	(Check 2 L Medical Exam	sician: To the best of my iner: On the basis of exan se Practioner: To the bes	mination an	id/or investig	gation, in my	opinion,	death occ	curred at t	he time, date ar	nd place	, and due to the	cause(s) and manner stated.	
To th	within To th comp		29b. Signature and title of departier	Ce,	To a second	50, 40	29c. L	icense n	umber	- piaco		29d. Da	te signed (Monti /10/10		
			30. Name and address of person who EJ Malhado 3110	Gracefield	Road	i; Sil	ver S	Sprin	ng, M	ary1	and 209	904			
	State Registra	~	31. Date filed (Month, Day, Year) AUG 1 7 2010	32. Registrar's	Signature	back	1								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month August Horace Lunt 2010 10:20 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Sinai Hospidal Baltimore Baltimore N/A 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 **X**M 2 □ F Hours Director 017-26-7096 Colorado 1918 Usual Residence of Decedent show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location Director 10d, Inside City Limits items 23a or 28a-f Middlesex 1 Yes 2 No Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1105 Mass Avenue 02138United States 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No 1942-Black, White, etc. "natural", or Completed by 1 Never Married 2 X Married Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White 3 🗌 Widowed 4 🗌 Divorced Horace Year or Dates 1945 27 is marked other than "nature traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Mental Hygiene. Professor University Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ eponld be Horace Lint Irene Jewett and 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sh tment of Health a tant: If item 27 is Elizabeth Lunt, Daughter 621 West University Parkway, Baltimore, Maryland 21210 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Baltimore, Knawn 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 8/14/2010 Baltimore, Maryland 21. Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facilit Cremation Society of Maryland, Inc. least. 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Preumonio disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) sician and burial-transit Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown Day Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş. pemphigoid Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed' certificate 1 Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other 4 Nursing Home 5 Residence 6 Other (Specify) ြ 1 🗌 Yes 2 410 ER/Outpatient 3 DOA 1 Impatient 2 this : After this funeral of 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 24 hours after deal Funeral Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) faitha Per August, 11, 2010 D65718 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital, 2401 WBelvedere AV, Baltimore Sinai HARITHA MD. 31. Date filed (Month, Day, Year) State 32. Registrar's Ş Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Marianne K. Liburdi August 6 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 6220 Charnwood Drive Rockville Montgomery 8. Date of Birth March 17, 1943 Social Security Number 6. Sex 7. Age (In yrs. last birthday If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Days Hours 1 □ M 2 🖾 F New Jersey 158-32-8416 67 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Rockville Montgomery 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 821 South Dean Street 21224 USA 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married white 1 ☐Yes 2 No Specify: 3 Widowed 41 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) healthcare psychotherapist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Phillip Joseph Kathryn Fabricatore 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6220 Charnwood Drive; Rockville, Maryland 20852 Gregory Joseph - brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, The Magnes.

Physician

/Medical

Examiner

10a. State

MD

Funeral

Director

28a-f show

ed other than "natural", or items 23a or 28a-f shore event, the Medical Examinar is ust be restlifted at

Completed by Funeral Director

Be

၉

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

as the burial-tran attending p s been signed by the should be detached has page 2 s certificate within 24 hours after death.

To the Funeral Director: A completely filled in by the fi

To the Hospital or Attending Physician; The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

B Medical Certification:

4 Donation 3 Other (Spec						
21. Signature of Funeral Service Vic	ensee Wady Director	22. Name and	Address of Facility St	ate Anat	omy Board	
Smill	1000	655 W	. Baltimore	Street;	Baltimore	, MD 21201
23a. Part 1. Enter the disease, or co shock, or heart failure. List on	mplications that caused the death. Do	o not enter the mode	of dying, such as cardia	c or respiratory ar	rest,	Approximate Interval Between
Immediate Cau Final disease or condition	METOSTA	De Ba	DST CC.	JUZA		Onset and Death
resulting in death)	Due to (or as a consequence					
Sequentially list conditions, if any, leading to immediate	b	A .				
cause. Enter Underlying Cause (Disease or injury	Due to or as a consequence	ce orj:				
that initiated events resulting in death) Last	Due to (or as a consequence	ce of):				
	d					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? in the past 15 months? g Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3 Ectopic pre			23d. Date of de Month	livery Day Year
art II. Other significant conditions	contributing to death but not resulting	g in the underlying cau	ise given in Part I.		bacco use contribute to es 2 XNo 3 □ P	
				24a. Was a autops perfor 1 □ Yes	med? death?	utopsy findings availab completion of cause of 2 □ No
25. Was case referred to medical examiner?				ath (Check only or	ne)	
1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/	Outpatient 3 DOA	Other: 4 \sum Nursing	Home 5 ☐ Resid	ence 6 KOther (Spe	city) BROTHER
27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	(Month, Day, Year)	o. Time of 286 Injury M	c. Injury at Work? 1 □Yes 2 □ No	28d. Describe h	ow injury occurred	
3 ☐ Suicide 6 ☐ Could not determined		farm, street, factory, o	office	28f. Location (S City or Town	treet and Number or R n, State)	ural Route Number,
29a. Certifier (Check only one) 1 Certifying F 2 Medical Example	hysician: To the best of my knowled miner: On the basis of examination and manner stated.	dge, death occurred at and/or investigation, i	the time, date and plac n my opinion, death occ	e, and due to the curred at the time, o	cause(s) and manner a date and place, and due	s stated. e to the cause(s)
29b. Signature and title of certifier		29c.	License number	2	29d. Date signed (Mont	h, Day, Year)
In fortun	20.	1	20018370		Elialia	

State Registrar ROAD

Lontenville MA 21093.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's S

Michael Leschk	e	State of Marylar 1- For State Registrar	nd / Departme <i>Certifica</i>			d Mental I		2 0 eg. No.	10 2554
Physici Medical Exam		Decedent's Name (First, Middle, Last) Micha	el Lesc	hke			2. Date of Dea Month August 4,	nth Day Year	3. Time of Death 0401 hrs
		4a. Facility Name (if not institution, give street and num 191 Saint Patricks Drive	ber)	41	o. City, Town, or I Waldorf	Location of Dea		4c. County of Charles	Death
Funeral Director		5. Social Security Number N / A 6. Sex 1 / A 1 / A 2 F	. Age (In yrs. last birth	nday) Yrs.	If Under 1 Year Months Days			Th(MM/DD/YYYY) 3/1963	Birthplace (State or Foreign NY Country)
Maryland 28a-f show any 1 at once.		Usual Residence of Decedent 10a. State	10c. City, Town o	or Locatio	Wald	dorf			10d. Inside City Limits
the Marylan a or 28a-f st iffred at onc	Director	10e. Street and Number 6060 Red Squirrel	Place		10f. Zip Code	0603	1	0g. Citizen of Wha	
hours after death with the Maryland 'natural', or items 23a or 28a-f sho Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Married Armed Ford 1 Yes 3 Widowed 4 Divorced If Yes, Give Year	dent Ever in U.S. ces? 2 X No	If Yes	Decedent of Hisp s, specify Cuban, es 2 No	Mexican, Puert	Specify Yes or No o Rican, etc.)	14. Race - White,	American Indian, Black, etc. White
1215-0036 Id be filed within 72 hours after dental Hygiene. narked other than "natural", event, the Medical Examines	Completed by	15. Decedent's Education (Specify only highest grade Elementary/Secondary (0-12) College (1-4)	dı	uring mos	Usual Occupation of working life.			16b. Kind of Busi	ness/Industry
MD 21215-0036 2 should be filed within 72 h and Mental Hygiene. 27 is marked other than " matic event, the Medical	Be	17. Father's Name (First, Middle, Last) Sigfried Leschke				In	ge Jar	Maiden Surname)	
MD 2 d 2 shou lth and h n 27 is n	T	19a. Informant's Name/Relationship (Type, Print) Sigfried Leschke /	Father D	orf	wiese 3	3, Wal	lmerod,		ту
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 2 injury or other traun		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from 4 Donation 5 Other Specify:	State Final	y or othe Jour	ney Cre	m. 8/	Date 10/2010	Woodbi	•
	9	21. Signature of Euneral Service License Donota	ushoul	22. Nar	Maryla PO Box	of Facility and Cro k 1413	emation , Balti	Servicimore, N	ces 1D 21203
Physician /Ledi Examiner		23a. Part I. Enter the disease, or complications that cau failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a co	shot Wound of H	enter the	mode of dying, s	such as cardiac	or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and Death
Mr.	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	onsequence of):						
executed an and al- transit	I Exan	(Disease or injury that initiated events resulting in death) Last Due to (or as a co	nsequence of):						
), be estician	Medical	UNPENDED AMENDED IF FEMALE: 23c. If yes, out	come of pregnancy					23d. Date of de	alivery
Box 68760 to death certificate by the attending physical for use as the bit.	Physician/M	23b. Was decedent pregnant in the past 12 months?	2 [t at time of death 5		death 3 (Specify)	Ectopic pregn	ancy	Month	Day Year
cords, P.O. law requires that the has been signed by the should be detached.	à	Part II. Other significant conditions contributing to de	eath but not resulting i	n the und	erlying cause giv	ven in Part I.	1 Yes	2 ✓ No 3	te to the cause of death? Probably 4 Unknown
Division of Vital Records, P.O. Box 68760 for the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b	Completed	OF Western visit 11 11 11					24a. Was a autop: perfor	sy prio med? dea	re autopsy findings available or to completion of cause of other the completion of cause of other the completion of the
Vital Rec	To Be	Tes 2 No		patient 3	DOA O	of Death (Check other 4 Nursin		Residence 6	Other: Scene
Sion of Attending Phyrdenth. ctor: After the by the funeral	ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of FOUND: Date of F	FOUN		· ·	at Work? s 2 ✓ No	28d. Describe h Subject shot	ow injury occurred self	
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	4 Homicide determined (Specify) F	f Injury - At home, farm				or Town, St St. Patrick's D	ate) rive, Waldorf, MI	
Fo the Ho within 24 Fo the Fu completel	Medical	Check only 2 Medical Examiner: On the basis of e and manner state	xamination and/or inve						
D 5	Σ	296 Sanature and title of certifier Calculation			29c. License r			29d. Date signed August 4, 20	(Month, Day, Year) 10
		30. Name and address of person who completed cause of Laron Locke MD. Assistant Medical E		Penn S	treet, Baltimo	ore, MD 212	01		
St Regist	~~~	31. Date filed (Month, Day Year) 32. Regis	rar's Signature	,					

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) conava Month Dav **Physician** 11, 2010 10:30^{a м} August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 45840 Guenther Drive Great Mills Saint Mary's 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 10/6/1928 9. Birthplace (State or Foreign **Funeral** Months M 2□ F Days Hours Min. 196-20-2996 81 Director Yrs. PAUsual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location f show a or 28a-f show be notified at 10d. Inside City Limits MD Saint Mary's Director Great Mills 1√2Xes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 45840 Guenther Drive 20634 USA items 23a Examiner must permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23 any Injury or other traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 MYes 2 □ NaNavy If Yes, Give Year or Dates: 1947-67 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 9 Specify: White 3 XWidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) <u>Radio Operator</u> Miliarv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joe Leonard Gertrude Finnigan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laurence R. Leonard/Son 45840 Guenther Drive, Great Mills, MD 20634 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Tremation 3 ☐Removal from State Final Journey Crem. 4 ☐ Donation 5 ☐ Other (Specify) 8/13/2010 Woodbine, MD 22. Name and Address of Facility
Maryland Cremation Services 21. Signature of Funeral Service Licensed Dorota Marshall PO Box 1413, Baltimore, MD 21203 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 515 disease or condition resulting in death) Medical Due to (or as a consequence of): xaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unisease or injury that initiated events Due to (or as a consequence of): Examiner the aftending physician and hed for use as the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a ☐Yes 2☐No 9☐ Unknown The law requires that the 9 Unknown Part II. Other significant conditions co. mibuting to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has e 2 page certificate 1∐ Yes or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) 2 No 1 ☐ Yes Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural
2 Accident 5 Pending investigation To the Hospita. C. within 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State

31. Date filed (Month, Day, Year)

30. Name and address to be Jennifer

on who completed cause of death (Item 23a) (Type, Print)
Schmidt, M.D., 40900 Merchants Lane, Leonardtown, MD

Registrar

H0055751

			For State	State of Ma	arylan		artment o			and M	ental Hy		71111	255	551
			Registrar 1. Decedent's Name (First, Middle, La				- Cate C	11 00			2. Date of De	Reg. N	0. 0 . 0	3. Time o	
	Physicia Medio		RUTHR.M	illman							Month August		2010 Year	3:00	
	Examir		4a. Facility Name (if not institution, given				4b. City, Tow	n, or Lo	ocation o				c. County of Dea		<u>u</u>
4000	,		Angel Gardens Ass	sisted Livi	ng				r Sp				Mor	tgomery	7
	Funeral		,	Sex 7. Age		ast birthday)	If Under 1 Ye Months Da		If Under 2 Hours		8. Date of Bir (Month, Da	th ay, Ye <i>ar)</i>	9. B	rthplace (State o	
	Director		577-14-0183 Usual Residence of Decedent		94	Yrs.					08/08/	1916	Det	roit, M	II
F	and show	힏	10a. State 10b. County		10c. City	, Town or Loc	ation				*			10d. Inside C	ity Limits
9KM	Maryl 28a-f otifier	Lec	Maryland Montgom	nery	Poto	omac								1 🏝 Ye	s 2 🗆 No
00	h the kaor; be no	a D	10e. Street and Number				10f, Zip Coo	de				10g. C	Citizen of What C	ountry?	
	th wit ms 23 must	Funeral Director	8513 Aqueduct Roa		_				854				USA		
40	r dea or itel		11. Marital Status1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ev Armed Forces? 1 \(\sum \) Yes 2 \(\overline{X} \) \(\overline{X} \)		5. 13. V	las Decedent of Yes, specify C	of Hisp Cuban,	anic Orig Mexican,	in? (Spec Puerto F	cify Yes or No- Rican, etc.)		14. Race - Am Black, Whi		
936	s afte ral", (Exan	sd be	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates.	10	1	☐ Yes 2 🔀	No	Specify:				Specify: W	hite	
5-0	hour "natu	Completed	15. Decedent's (Specify only highest g			16a. Deced	ent's Usual Oc	ccupation	on	a f a while		16b.	L Kind of Business	Industry	
21	hin 72 ne. than '	E	Elementary/Seconday (0-12)	College (1-4 or 5-	-)	life. DC	ind of work do NOT use retir	red)	_		•				
2	d wit tygie ther nt, th	Be C	17. Father's Name (First, Middle, Last)	2		Admini	istrati						<u>leral Go</u>	vernmen	t
anc	be file ental } ked o c eve	l o l	Israel Robert Rom					- 1			(First, Middle,	Maiden	Surname)		
Σ̄	ould Ne Me mark	1	19a. Informant's Name/Relationship (10h Mailin	a Address /Str		sthe			r City o	or Town, State, Z	in Codel	-
Ž	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. The shammand Mental Hygiene. The marked other than "latural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Linda Nemiroff, d	, , ,			Aquedu							20854	
ore,	of Her of Her fitem rothe		20a. Method of Disposition		20b. Pl	ace of Dispos	sition (Name of atory or other)	f			ate		ocation - City o		
<u>ii</u>	Page 1 ment of ant: If it ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	I Removal from State cify)			anon C		0	8/11	/2010	Ade	elphi, M	aryland	
Baltimore, Maryland 21215-0036	permit. Page 1 Department of Important: If it any injury or o once.		21. Signature on Funeral Service Licer	nsee	MO10	22. EI	Name and Ad	dress d AGĘ	of Facility	ŅĘŖA	L DIRE	СТІС	N, INC. Le, Mar		0050
		\dashv	23a. Part 1. Enter the disease, or cor	mplications that caused	MO12	Do not enter	the mode of o	KV1	.TTe	P1ke ardiac or	, Rock	Vill rest	le, Mar	yland 2 Approxima	
20. 4	hysician/		Immediate Cause (Final	one cause on each line.	Inti	•		-73, -			,			Interval Bet Onset and	ween
	Medical		disease or condition resulting in death)	Due to (or as a	conseque	u ence of):		_				_		years	
	Examiner		Socuration, list and diving	,	·	- 7									
	ed nsi t	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequ	ence of):									
•	To the toyptal or Authoring Prystician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burlal-transit.	Exa	that initiated events resulting in death) Last	c. Due to (or as a	conseque	ence of):							-		.
09	te be nysicia ne bur	dical		d											
87(rtifical ing ph e as th	Mec	IF FEMALE:												
×	ith ce	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	☐ Fetal	death 3 🗌	Ectopic pregn					1	23d. Date of de	-	Year
m.	rhe a	Physician/Me	1 Yes 2 No	4 ☐ Pregnant at t 9 ☐ Unknown	ime of de	eath 5□	Other (specify	/)					MOITH	Day	rear
0.	that the	by P	Part II. Other significant conditions	contributing to death but	not resu	Iting in the un	derlying cause	e given	in Part I.		23e. Did to	obacco	use contribute to	the cause of d	leath?
<u>v</u> .	urres 'n sigr										1 🗆	Yes 2	□ No 3 □ F	robably 4 🗹	Unknown
Örc	w required is pee	plet									24a. Was		24b. Were au	topsy findings	available
Rec	rne la ate ha page	Completed									autor perfo	rmed?	death?	completion of c	ause of
ta .	cran: ertific actor,		25. Was case referred to medical examiner?	112-1					of Death	(Check o					
Į K	Pnysi this c	은	1 Yes 2 No	Hospital: 1 Inpatier 28a. Date of injury		R/Outpatient	3 L DOA						6 Other (Spec	Assiste	LIVING
0 "	dung h. After funer	cate	1 Natural 5 ☐ Pending	(Month, Day,	Year) '	28b. Time of injury	W	njury at vork?	s 2 🗆 N	- 1	3d. Describe h	ow injur	y occurred		
sio	r deat ctor:	Certificate:	2 Accident Investigation 3 Suicide 6 Could not I 4 Homicide determined	be Ologo of Injury	/ - At hon	ne, farm, stree				-	Bf Location (S	Street an	d Number or Ru	ral Route Numb	ner
Division of Vital Records, P.O. Box 687	rar or safte rs afte al Dire		4 - Holflicide determined	building, etc.	(Specify)						City or Tow			ray Houte Wallie	,01,
	4 hour	edical	29a. Certifier 1 Certifying Phy (Check 2 Medical Exam	ysician: To the best of m	y knowle	dge, death or	cured at the ti	ime, da	ite and pl	ace, and	due to the ca	use(s) ar	nd manner as st	ated.	nner stated
	thin 2 the F	Σ .	only one 3 Certifying Nur 29b. Signature and title of certifier	rac Practioner: To the be	at of my	ter owledge; de	with consumed at	t the ti	ive; date a	and place	and due to the	cames(e) and manner at	etated -	inici stated.
	5.≱ ₹. 6		- // // :	ras, mo			29c. Lice		00 mber	1			te signed (Mont.	n, Day, Year)	
		1	30. Name and address of person who	completed cause of dea	th (Item !	23a) (Tuno Dei	int)								
10			JAY LIPPM	AN MA 7	05	DIGITAL	OR S	TE	fi (LINT	HICUM	M)	21090		
	Stat	-	31. Date filed (Month, Day, Year)	32. Regiştrar											
V	Registra		July 4	MA MA	P ;										
Y DHM	H 17 Rev 7/200	09													

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 25552 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SA NR Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Seasons Hospice Baltimore Randallstown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days XXM2 DF Months Hours Min. 9-17-1942 Country) 67 Director 146-34-0362 Yrs NJUsual Residence of Decedent 28a-f shov 10a. State 10b. County filed within 72 hours after death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notifled at 10c. City, Town or Location 10d. Inside City Limits Director Owings Mills Baltimore 1 Yes 2XX No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9902 Middle Mill Dr. 21117 United States 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married 2 X No ☐ Yes Yes, Give Baltimore, Maryland 21215-0036 "natural", 1 ☐ Yes 2 X No Specify: 3 Divorced Completed White Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) ith and Mental Hygiene.
27 is marked other than "r r traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Pyscologist Psychology Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ၉ should be Joseph Miller Florence Knoller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Valgred M. Miller (wife) 9902 Middle Mill Dr. Owings Mills, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or ot 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation Other (Specify) Carroll Cremation, Inc 8-18-2010 Hampstead, MD 21. Signi 22. Name and Address of Facility Eline Funeral Home ervice Licase Wayne Osterling 11824 Reisterstown Rd. Reisterstown, MD 21136 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part 1. Enter the Approximate shock, or heart f Interval Between mediate Cause (Final disse or condition resulting in 12 th) Onset and Death Physician Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) attending physician and I for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death 2 No Yes been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been signated by page 2 should by 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \) 24a. Was an autopsy performed? Yes 2 No this certificate filled in by the funeral director, To Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital Other: 2 **S**No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 24 hours after death. Funeral Director After 28d. Describe how injury occurred Natural
Accident
Suicide
Homicide 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Within 2 only one) 29b. Signature and title 29d. Date signed (Month. Day, Year,

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause

31. Date filed (Month, Day, Year)

of death (Item 23a) (Type, Print)

6

32. Registr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mary Frances Marion 2010 August 14 7:40a Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapois Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🕱 F Days Oct. 16, 1927 New York 121-18-6262 Yrs. Director 82 Usual Residence of Decedent or 28a-f show notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Anne Arundel **Annapolis** 10e. Street and Number ò 10g. Citizen of What Country? traumatic event, the Medical Examiner must be 23a Funeral 7030 Channel Village Court Apt.T2 21403 United States items 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. ō δ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Tes 2 No Specify. 3 🛚 Widowed 4 🗆 Divorced "natural" Completed Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 2 should be filed within 72 in the and Mental Hygiene. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Executive Assistant Architecture and 2 should be filed wit Health and Mental Hygie tem 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ George Van Riper Mary Hahn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Matthew Marion, Son 16 Harstrom Place, Rowayton, Connecticut 06853 item Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ot 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Metro Crematory, Inc. 8/16/2010 Baltimore, Maryland Signature of uneral Service Licensee manda Heaston 22. Name and Address of Facilitermation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ RESPIRATORY FAILURE disease or condition resulting in death) Medical Due to (or as a consequence of Examiner METASTATIC CERVICAL Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury the bunal-tran and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician ned for use as the bunal Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day 9 Unknown Unknown been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 K Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has page 2 autopsy perform 1 Yes 2 KNo completed filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital Certificate: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending injury work 1 Yes 2 No Accident Investigation after death 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 To the within 2 only one) 29b. Signature and title of certi 29c. License number D64852 8/14/2010 30. Name and address of person who comed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

900 BESTGATE

32. Registrar's Sig

GARG

201U

31. Date filed (Month, Day, Year)

RUAD SUITE 300 ANNAPOLIS, MOZIYU

		For State Registrar	Plea			ind / De	a Indelible In Epartment of Certificate of	Health and N	Mental Hyg			e. N. 25554
Physicia Medi		1. Decedent's Nam		_{Last)} leyerhof	fer				2. Date of Dea Month —	th Day	Yea 201	3. Time of Death 7: 15 P.M
Exami		4a. Facility Name (ii Union		give street and nur. al Hosp				or Location of Death imore		4c. (County of D	eath
Funeral Director		5. Social Security N	-9962	6. Sex 1 ☐ M 2 🔼 🗲	7. Age (In yrs	. last birthda 88 Yrs	Months Dave		8. Date of Birtl (Month, Day Apr	(Year)	9. 1922	Birthplace (State or Foreign Country) Virginia
iryland a-f show ïed at	Director	Usual Residence of 10a. State	10b. County		10c. C	City, Town or		·				10d. Inside City Limits Yes 2 □ No
he Ma or 28¢		10e. Street and Nu	mber			Dalt.	10f. Zip Code			10g. Citiz	en of What	Country?
with t s 23a ust bo	Funeral	3402 W	hite Av	e.			212	14		U	nited	States
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 1 Never Mari		Armod E	2. No ve	J.S.	13. Was Decedent of If Yes, specify Cub	oan, Mexican, Puerto	ecify Yes or No- Rican, etc.)		4. Race - A Black, W Specify:	merican Indian, hite, etc. White
hours natur	lete		15. Deceden	t's Education		16a. De	ecedent's Usual Occu	pation	king	16b. Kir	d of Busine	ss Industry
thin 72 ane. than " he Mec	Completed by	Elementary/Sec	conday (0-12)	ct grade completed College (*		life	e. DO NOT use retired	duning most of work (1)	ang	S	tato	of Maryland
led wi Hygie other	Be	17. Father's Name		ast)] - 2	Secretary	18. Mother's Nan	ne (First, Middle,			or mary mana
d be fi Aental arked tic ev	₽	Clue	Andrew N	Meyerhoffe	r			Delta	Philli	ps		·
d 2 shoult alth and N 27 is ma er trauma		19a. Informant's N Linda	ame/Relationsh				failing Address (Stree	t and Number or Rui te Ave. Ba				
Page 1 an nent of He ant: If iten Iry or oth				3 ☐ Removal fron		cemetery,	isposition (Name of crematory or other place) and Memor:		Date Aug 17 n: 2010	,	-	or Town, State
permit. Departn Importa any injt		21. Signature of Fu	uneral Service L	censee	Hol	1443	22. Narce and Add	Pon Family Fu	neral Al			ryland 21286
Physician/		shock, or hea Immediate Cause disease or condition	art failure. List o (Final on	nly one cause on e	ach line.	sho	enter the mode of dy					Approximate Interval Between Onset and Death
Medical Examiner		resulting in death)			(or as a conse		difficile	Colitis				1 month
executed an and rial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):									24 hours	
ate be exe physician the burial	<u></u>	Garage Control of the										24 hours
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was deceden in the past 12 1 Yes 2 9 Unknown	months?		Birth 2 ☐ Fo gnant at time o	etal death	3 Ectopic pregna 5 Other (specify)	ncy	-	2	3d. Date of Month	delivery Day Year
ires that the signed by the detail	þ	Part II. Other signi	ificant conditio	ns contributing to	death but not r	resulting in t	the underlying cause	given in Part I.				e to the cause of death? Probably 4 🗆 Unknown
e law requents beer	Completed				<u> </u>					osy rmed?	prior deatl	
an: Th tificate tor, pa	l ø	25. Was case refer	red to medical				26.	Place of Death (Chec	1 🗌 Yes	2 X No	1 🗆	Yes 2 No
nysicia nis cer direct	70 B	examiner? 1 Yes 2	⋈ No	Hospital:	Inpatient 2		atient 3 LI DUA	ther: 4 Nursing H	lome 5 🗌 Resid	dence 6	Other (S	pecify)
anding Pl sath. or: After th	Certificate:	27. Manner of Dear 1 X Natural 2 Accident	5 Pendin _ Investig	ation	e of injury nth, Day, Year)	28b. Tim inju	iry wo	ury at urk? Yes 2 No	28d. Describe h	ow injury	occurred	
tal or Atterns atterns al Directe		3 Suicide 4 Homicide	6 🗌 Could determ	, 28e, Plac	e of Injury - At ling, etc. <i>(Sp</i> ec	home, farm	, street, factory, office		28f. Location (S City or Tow		Number or	Rural Route Number,
the Hospi nin 24 hou the Funer	Medical	(Check only one)	2 ☐ Medical E 3 ☐ Certifying	vaminer: On the ha	sis of examina	tion and/or in	lge, death occurred at	nion, death occurred the time, date and pla	at the time, date a ace, and due to the	ind place, e cause(s)	and due to t and manne	the cause(s) and manner stated ras stated.
To t To t		29b. Signature and	freight	, M.D			AT 2	15e number 243 89 4	6	08	, 13,	2010
		30. Name and add	ALFR	EIJAT			pe, Print)	IT al 201 E.	Universit	1 Acm	y, Bal	Timore, MO 21218
Sta	ite	31. Date filed (Mon	nth, Day, Year)	32.	Registrar's Sig	nature						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Marist 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Date of Birth (Month, Day, **Funeral** Year) 1 M 2 F 58 Yrs 02, 1952 Maryland Jul 212-60-6730 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show at 1 ☐ Yes 2 No r 28a-f s notified Director MD Randallstown Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code ö must be 23a 21133 United States 3503 Fox Cliff Ct. Apt. T-2 Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes → No If Yes, Give Year or Dates: items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status Examiner and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 ō 1 ☐ Yes 21☐ No Specify. þ Specify 3 ☐ Widowed 4 Divorced Black 'natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education the Medical (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) 12 Own Home Homemaker other (event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be of Health and Mental H fitem 27 is marked oth r other traumatic even Joseph Miller Margaret Hackett မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Trina Crosby /Daughter 3503 Fox Cliff Ct. Apt. T-2 Randallstown, MD 2113 Department of Heali Important: If item 2 any Injury or other once. Pages 1 a 20a. Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Aug 16 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2010 Chesapeake Crematory 21. Sigrature of Funeral Service Licensee 22. National Alternatives MO1443 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** upper gastrointes nastrointestinal disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Box 68760, physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ of Vital Records, 2 No 1 Tyes 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 2 No 1 Yes Yes Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ပု this completely filled in by the funeral 27. Manner of Death 11 Natural 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: I or Attending P after death. Director: After t Division 5 Pending investigation (Month, Day Year) 1 Yes 2 No Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State) 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (check only one) To the l within 2 To the F 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

State Registrar MD

MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

-. Smith

Rebecca

31. Date filed (Month, Day, Year)

RES-000

August 13,2010

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ForStateRegistrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 80 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMER' CROS ING 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Days Months Hours **Director** Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 V Yes 2 No MD 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral RIZIA BELCREST 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) should be filed within 72 In and Mental Hygiene.
Is marked other than "r College (1,-4 or 5+) Elementary/Seconday (0-12) B INFAL INFANT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ EFF permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic MANE ROSEMARY EMEHIAIR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CROSS GLRN RD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 ₩ Other (Specify) in state Signal Ronald S. Wa 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore Street; Baltimore, MD 21201 . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PREMAT XTREME disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): ysician and e burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 phys the b attending p IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 1 Yes 2 L 9 Unknown detached 9 Unknown þ s been signed b should be deta Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death? page 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Other: 2 No မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Natural 5 Pending work? 2 No Accident Investigation 24 hours after deat Funeral Director: Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. only one 29b. Signa e and title of ce 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARNIC 7582 2 MD GENEA 109AUUR MAHIAM 31. Date filed (Month. Day, Year 32. Registrar Signat State

Registrar

				Department of Health and	Mental Hygiene
	_		State Registrar	Certificate of Death	Reg. No. 2010 25557
	Physicia	an/	1. Decedent's Name (First, Middle, Last) LDV MLCVLVM		2. Date of Death Month Day Year AU6/(51 14) 2000 0378 M
-5	Medi	cal			
	Exami	ner	4a. Facility Name (if not institution, give street and number) NTNTHWEST HRSP)TAL	4b. City, Town, or Location of Death	4c. County of Death BALSIMURE
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bir	1 1 1	8. Date of Birth 9. Birthplace (State or Foreign
	Director		240.44.7733 1 M 2 XF 78		(Month, Day, Year) Country) NC
	and show d at	٦.	Usual Residence of Decedent 10a, State 10b, County 10c, City, Tow		
	Marylan 28a-f sh notified a	[왕	0 11:00:00	NYM Dak	10d. Inside City Limits 1 □ Yes 2 ★No
	or 28 or 28	 	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
_	with t	Funeral Director	3 Joicy Court	21207	13A
	death with the Maryland ritems 23a or 28a-f sho ner must be notified at	E	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp.	Dices etc.
36	after or I", or camir	<u>a</u>	1 Never Married 2 Married 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto	Black, Write, etc.
215-0036	72 hours after n "natural", or fedical Exami	Completed	Year or Dates.	Decedent's Usual Occupation	specify: Black
715	n 72 h an "na Media	ם	(Specify only highest grade completed)	Give kind of work done during most of work life. DO NOT use retired)	* * * * * * * * * * * * * * * * * * * *
21,	withir giene er th		Elementary/Seconday (0-12) College (1-4 or 5+) SH1 QV acle N/A	Housevife	Home
pu	tal Hy tal Hy od oth eveni	To Be	17. Father's Name (Erst, Middle, Last)	1 4 .	ne (First, Middle, Maiden Surname)
yla	should be filed within 73 and Mental Hygiene. is marked other than aumatic event, the Me	-	Contey Mainor, Jr.	Ada (re Ferguson
Maryland	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type, Print) 19k. 19k. 19k. 19k.		ral Route Number, City or Town, State, Zip Code)
ē,	and Heal tem 2			B Joicy Court GWI	Date 20c. Location - City or Town, State
Baltimore,	permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau		1 Burial 2 Cremation 3 Removal from State cemete	ry, crematory or other place)	20/2010 Windson Mill, MD
altii	mit. F partm sorta / injur		21. Signature of Funeral Service Licensee		Myhn C. Gueene Puneral Services
Ä	an De o		Vaugh C.	8728 Liberty Road	Randallstown MD 21133
			23a. Part 1. Enter the disease, or complications that caused the death. Do r shock, or heart fadure. List only one cause on each line.		
34	Ph_sician/		Immediate Cause (Final disease or condition		Onset and Death
4	Medical Examiner		resulting in death) Due to (or as a consequence of	ર્ગ):	
		ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of	าปี'	
J.	ted d unsit	Examiner	cause. Enter Underlying Cause (Disease or finjury		
A	Attending Physician: The law requires that the death certificate be executed and each. The cape of the control		that initiated events resulting in death) Last C. Due to (or as a consequence of	of):	
09	ate be ohysicia the bur	edical	d		
Box 68760	rtifica ling p e as t		IF FEMALE:		
) XC	ath certific attending p	ian	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death		23d. Date of delivery Month Day Year
Ğ.	the a	Physician/M	1 ☐ Yes 2 No 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 U Other (specify)	Worth Day lear
P.O.	ires that the dea signed by the a id be detached f	y P	Part II. Other significant conditions contributing to death but not resulting it	n the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
JS,	uires in sign	Completed by			1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📆 Unknown
Ö	aw require as been si 2 should	plet			24a. Was an 24b. Were autopsy findings available prior to completion of cause of
Rec	iician: The law certificate has rector, page 2	le le			autopsy prior to completion of cause of performed? death? 1 □ Yes 2 □ No
tal	lysician: is certific director,	Be (25. Was case referred to medical examiner?	26. Place of Death (Chec.	
fΥ	Physi this o	은	1 Inpatient 2 ER/Ou	2	ome 5 Residence 6 Other (Specify)
n o	ding l th. After funer	ate	1 Natural 5 ☐ Pending (Month, Day, Year) ir	ime of 28c. Injury at vork? M 1 Yes 2 No	28d. Describe how injury occurred
Division of Vital Records,	Attendii r death. cctor; Af yy the fu	Certificate:	2 ☐ Accident Investigation 3 ☐ Sulcide 6 ☐ Could not be 4 ☐ Homicide determined determined		28f. Location (Street and Number or Rural Route Number,
N	alor, s afte il Dire		building, etc. (Specify)	, , , , , , , , , , , , , , , , , , , ,	City or Town, State)
	lospit t hour unera ed fille	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, of Check 2 Medical Examiner: On the basis of examination and/or	death occured at the time, date and place, ar	nd due to the cause(s) and manner as stated.
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral		only one) 3 L Certifying Nurse Practioner: To the best of my knowledge	edge, death occurred at the time, date and place	
	© 2 ∰ 2		29b. Signature and title of certifier M Ahr mo	29c. License number	29d. Date signed (Month, Day, Year)
	.\		30. Name and address of person who completed cause of death (item 23a) (1	(me Print)	00000
	H		CLIFF FABER, MO 590, 020 C	DURY ROAD RAND	29d. Date signed (Month, Day, Year) A V G V S 1 1 2010 A L L S T D W M A R Y L A W S
	Stat	-	31. Date filed (Month, Day, Year) 32. Registrar's Signature	a Val)
	Registra	ır	AUG 172010 Bure 1. A.		

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene 25558 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month August 8 Day 2010 **Physician** 7:45 P M Kenneth Lewis Meile /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1506 Hazel Street Curtis Bay N/A 8. Date of Birth (Month, Day, Year) Sex 1 ☑ M 2 ☐ F If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 47 Dec. 1962 216-86-8356 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or items 23a or 28a-f show ¥ Yes 2 No Be Completed by Funeral Director MD N/A Curtis Bay 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1506 Haze1 Street 21226 USA filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No white Specify. Specify: if Item 27 is marked other than "natural", o or other traumatic event, the Medical Expri 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Disabled Disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Brenda Gustafson Raymond Meile ပို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i 1506 Hazel Street, Curtis Bay Maryland 21226 Beverly Meile-wife Department of Healt Important: if Item 2; any Injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Atlantic 8/14/10 Glen Burnie 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home Inc. 1328 Sulphur Spring Rd. Arbutus MD 21227 neral Service License Approximate Interval Between 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final locardia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ensive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-transit P.O. Box 68760 Due to (or as a consequence of) Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months? Month Day Year 5 Other (specify) TYes 2 No. After this certificate has been signed by the a funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by No 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy 1 ☐ Yes Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Natural 5 Pending investigation Injury To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: A completely filled in by the fu 1 ☐Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signa 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) timore, MD alaca nintan 30 31. Date filed (Month, Day, Year) State AUG 1 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 2315 M Thomas Ross McArthur 2010 August Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore N/A If Under 1 Year I If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Jan. 19, 1957 Min. 1 **X** M 2 □ F Michigan 220-68-1257 53 Director Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Examiner must be notified at Director 1 Yes 2 X No Catonsville MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21228 United States 14 Merrill Court, Apt. B or items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: "natural", 3 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Automotive Mechanic Be permit. Page 1 and 2 should be filed or Department of Health and Mental Hyy Important: If item 27 is marked othnany injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ruth Agnes ဂ Ross McArthur 19a. Informant's Name/Relationship (Type, Print)
Cindy McArthur - Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1401 Barrett Rd., Baltimore, MD 21207—4808 Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Atlantic Crematory Aug. 12,2010 Glen Burnie MD Donation, 5 U Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Cardino tuen 4 min Medical Due to (or as a consequence of) Examiner ALUKE Lonnar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical signed by the attending particle is a signed for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an or Attending Physician: Division of Vital 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 40 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 🗌 No To the Hospital or Attendi within 24 hours after death To the Funeral Director: A 1 Yes ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) BL9916795 Jugust 7, 2010 M1) 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21229 MB 900 South Caton Avenue Bultimore Meghan Checkley

State

Registrar

31. Date filed (Month

Year)

AUG 172010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 28 State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 - For A State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician zabeth 8 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Finksburg, //
If Under 1 Year | If Under 24 Hrs. arroll County Birthplace (State or Foleign Country) 8. Date of Birth (Month, Day, Year) July 20 1924 Age (In yrs. last birthday) **Funeral** Min. 1 ☐ M 2 💢 F Months Days Hours 24 6610 86 MARYLAND Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 No FINKSBURG MO CARROLL Director 10g. Citizen of What Country? 10e. Street and Number PARK ROAD USA 21048 2021 DEER Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE Completed by 3 Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOME MAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BROOKS YOUNG SARAH ပ KENNARD ELIZA BETH 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PARK ROAN FINKSBURGMO 21048 KENNARD MUSE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 8/18/2010 FINKSBURG, MD FINKSBURG METH.CEM! 22. Name and Address of Facility J N Zum Brun FH & mon Co. 21. Signature of Funeral Service Licensee RO ELDERSBURG-MO 21784 6028 SYFESVILLE 23a. Part V Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) angement Physician /Medical Due to (or as a consequence of): **Examiner** uamo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as Examiner burial-transit Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown After this certificate has been signed funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2▲No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) nours after death.

neral Director: After this of tilled in by the funeral dire 2**00**0 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 1 ☐ Yes 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Injury 5 Pending investigation 1 🗌 Yes 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite Falls Rd 10 Rowland-Seymour

State Registrar

mastasia 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Carla Elizabeth Moore August 2010 9:30 A. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Holy Cross Hospital Silver Spring Montgomery If Under 1 Year I If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 M 2 K F 6/28/1954 Director 379-62-7021 56 Ohio Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. It item 27 is marked other than "natural", or items 23a or 28a-f shoi ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director iral", or items 23a or 28a-f s Examiner must be notified D.C. 1 x Yes 2 No Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2726 Connecticut Avenue, N.W. U.S.A. 20008 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?
1 ☐ Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 2 Maryland 21215-0036 1 Yes 2XXNo Specify: If Yes. Give **Black** 3 Widowed 4XXDivorced Specify. Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) National Bank of Detroit Banker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ James Wilson Mary Munger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Brown (Mother) 2726 Connecticut Avenue, N.W. #502 Wash. D.C. 20008 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1
Department of I
Important: If it
any injury or of 1 Burial 2 X Cremation 3 Removal from State Metropolitan Crematory 8/14/2010 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VIrginia 22. Name and Address of Facility Marshall March Funeral Homes Signature of Funeral Service Licensee 4217 9th Street, N.W. Washington, D.C. 23a art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Respiratory Failure disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Multiple Sclerosis Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🕱 No 5 Other (specify) Month Pregnant at time of death Day Year be detached g Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed' within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page Yes 2 X No 1 ☐ Yes 2 🔀 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 \(\subseteq \text{Yes} Other: ျ 2XX No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending work? 2 🗆 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Pyactioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

500 Forest Glen Road Silver Spring, Md.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sig

Ruban, M.D.

AUG 1 7 2010

D0063343

August 13, 2010

	1 – For State Registrar	State of Maryland	d / Department of H Certificate of L		ntal Hygiene Reg. Né	211111	25562
hysician /Medical	1. Decedent's Name (First, Middle, La Haywood	Mayo			Date of Death Month Pa	Year	3. Time of Death
Examiner uneral	5. Social Security Number 6. S	+ OSPITAL ex 7. Age (In yrs. le	BALT ast birthday) If Under 1 Year	If Under 24 Hrs. 8. If Hours Min.	Date of Birth	BALT IN	
ector	Usual Residence of Decedent	X M 2 □ F 83	Yrs. Months Days	Hours Min. M	ay2,192	7 N.	Carolina
event, the Medical Examiner mast be notified at Be Completed by Funeral Director	Md. 10b. County		altimore		10-0)	10d. Inside City Limi
ral Dir	10e. Street and Number 713 Maidencho		10f. Zip Code 2120		U.	tizen of What Co	ountry ?
by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 Types 2 No If Yes, Give 52-5		ispanic Origin? (Specify an, Mexican, Puerto Rica Specify:	Yes or No- in, etc.)	14. Race - Ame Black, White Specify: B1	e, etc.
Completed	15. Decedent's El (Specify only highest gra Elementary/Secondary (0-12)	ducation ide completed) College (1-4or 5+)	16a. Decedent's Usual Occup. (Give kind of work done of life. DO NOT use retired	ation during most of working f)		Kind of Business	Industry Maryland
To Be Co	12 17. Father's Name (First, Middle, Last James Mayo		Supervice	18. Mother's Name (Fin	rst, Middle, Maider		mar y raira
r traum	19a. Informant's Name/Relationship (Carla A. Jac	**	19b. Mailing Address (Street at 1301 N.Stri	and Number or Rural Ro	oute Number, City		
ury or othe	20a. Method of Disposition 1	nemoval nom State	ace of Disposition (Name of imetery, crematory or other placers) rison VA.Cem	Date	20c. L	ocation - City or	
any injury or once.	21. Signature of Funeral Cervice Lice	Solo P	22. Name and Address Estep Br 1300 Eut	ss of Facility Pothers Fu aw PLace,			
ician dical	23a. Part 1. Enter the I sease, or com shock, or hear failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that aused the death one cause on each line. a. CEUVLIT Due to (or as a consequence)	Do not enter the mode of dyin	g, such as cardiac or re	spiratory arrest,	VIII. VIIII. VIII. VIII. VIII. VIIII. VIIII. VIIII. VIII. VIIII. VIII. V	Approximate Interval Between Onset and Death
dical Examiner	Sequentially list conditions, if any, leading to intrinsidate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. EX FOLIAT Due to (or se a conseque c. PSORIAS I Due to (or as a conseque d.	ence ory:	ODERMA			UNKNOW
by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3 Ectopic pregnancy	у		23d. Date of de Month	livery Day Year
	Part II. Other significant conditions	ontributing to death but not resul	iting in the underlying cause give	en in Part I.	23e. Did tobacco 1 ☐ Yes 2		o the cause of death?
Somp					24a. Was an autopsy performed? 1 □ Yes 2 □ X	prior to death?	utopsy findings availa completion of cause s 2 No
f director.	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1,⊠Jnpatient 2 ☐ E	ER/Outpatient 3 DOA Other	26. Place of Death (Cler: 4 ☐ Nursing Home		6 ☐ Other (Spe	ecify)
completely filled in by the funeral dir Medical Certification: To	27. Manner of Death 1 Natural 2 Accident 3 Suicide 6 Could not b	(Month, Ďay, Year)	28b. Time of lnjury M 28c. Injur Work 1 1	k? Yes 2 □ No	Describe how inju		unal Cauda Alumbar
I Certif	4 Homicide determined	building, etc. (Specify			City or Town, Stat	te)	ural Route Number,
Medical		niner: On the basis of examinat and manner stated.	ion and/or investigation, in my o	ppinion, death occurred a	at the time, date ar	ate signed (Moni	e to the cause(s)
completely filled Medical Ce	30. Name an address of person who	, completed cause of death (from	23a) (Type, Print) NONDS FERRY	5761	Au	<i>igust</i>	7, 2010
	oo. Ivame an address of person who	completed dause of death (item)	Low (Type, Fill)				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	State of Mar		tificate of L		Re	eg. No.2010	25563		
	Physicia: Medic		1. Decedent's Name (First, Mide		ert Mitche	11		2. Date of Death Month	ug ^{Day} , 2010 ^{Year}	3. Time of Death 12:15a _M		
9	Examin		4a. Facility Name (if not institution	on, give street and number) Stella Maris		4b. City, Town, or	Location of Death	nium	4c. County of Death	imore		
I	Funeral Director		5. Social Security Number 580-12-1223		n yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 22	9. Birt (Co. (1934 V	9. Birthplace (State or Foreign 934 West Indies		
	ryland a-f show ied at	ctor	Usual Residence of Decedent 10a. State 10b. Coun	ty 1	0c. City, Town or Loc		altimore			10d, Inside City Limits 1 X Yes 2 No		
	vith the Ma 23a or 28e st be notif	eral Dire	Maryland 10e. Street and Number 5915 Arizona Aver			10f, Zip Code	21206	1	0g. Citizen of What Co	untry?		
а.ш.	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Merical Examinar must be notified at once.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ M 3 □ Widowed 4 □ Divorc	12. Was Decedent Eve Armed Forces? 1 Yes 2 No		Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Spe n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amel Black, White Specify:			
12:15 а.ш 21215-0036	ithin 72 hou ene. r than "natu he Meriica	Complet		dent's Education hest grade completed) College (1-4 or 5+)	(Give I	O NOT use retired)	during most of work	ing	16b. Kind of Business State Of	industry Maryland		
	be filed wi ental Hygia ked other ic event, t	d)	17. Father's Name (First, Middle	, Last) shton Mitchell	I		18. Mother's Nam		laiden Surname) cia Mitchell			
2010 Aaryland	2 should b th and Mei 27 is mark traumatic		19a. Informant's Name/Relation				and Number or Rura Avenue Baltin		City or Town, State, Zip	Code)		
AUGUST 9, Baltimore, N	Page 1 and 2 s ment of Health and: If item 27 ant: If item 27 ury or other tra		Lima Mitchell 20a. Method of Disposition 1 Burial 2 Crematic 4 Donation 5 Other	in 3 Removal from State	20b. Place of Dispo cemetery, cren		ce)		20c. Location - City or	Town, State e, Maryland		
AUGUST Baltimor	permit. Po Departme Importan any injuran once.	1 1 1 1	21. Signature of Funeral Service			. Name and Addre		_	P. A.			
	Physician/ Medical		23a. Part 1. Enter the disease, shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	or complications that caused the tonly one cause on each line. PROSTATE	CANCER	1300 F er the mode of dyin	g, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death		
092	physician and the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Due to (or as a condition of the cond	consequence of):							
L.I. Box 687	To the Hospital or Attending Physician: The law lequires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has I een signed by the attending pl completed filled in by the funeral director, page 2 should be detached for use as t	Physician/Me	IF FEMALE: 23b, Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1	Fetal death 3	Ectopic pregnand Other (specify)	су		23d. Date of del Month	livery Day Year		
HERBERT MITCHEL!	uires that the n signed by uld be detac	ed by Ph	Part II. Other significant cond	itions contributing to death but	not resulting in the u	nderlying cause gi	ven in Part I.	23e. Did tob	es 2 No 3 P	the cause of death?		
BERT MIT Records,	The law 'eq atc has l ee page 2 shou	Completed						24a. Was ar autops perforr 1 Yes	ned? prior to death?	topsy findings available completion of cause of		
HERE Vital	sician: certific	To Be (25. Was case referred to medic examiner? 1 ☐ Yes 2 🗶 No	Hospital:	t 2 🗆 ER/Outpatier	Oth	er:		ence 6 V Other (Spec	ify) HOCDICE		
on of V	nding Phy ath. r: After this ie funeral d	Certificate: T	27. Manner of Death 1 X Natural 5 Pen 2 Accident Inve	28a. Date of injury (Month, Day, 1)	28b. Time of	28c. Injur worl	y at		w injury occurred	HUSPICE		
Division	al or Atte s after de il Directo ed in by th	I Certii	3 ☐ Suicide 6 ☐ Cou 4 ☐ Homicide dete	ld not be rmined 28e. Place of Injury building, etc. (- At home, farm, str (Specify)	eet, factory, office		28f. Location (Sti City or Town	reet and Number or Ru , State)	ral Route Number,		
	n 24 hour n 24 hour ne Funera	Medical	(Check 2 Medica	ng Physician: To the best of mill Examiner: On the basis of exa ng Nurse Practioner: To the be	mination and/or invest	tigation, in my opini	on, death occurred a	t the time, date an	d place, and due to the	cause(s) and manner stated		
	To the within comp		29b. Signature and title of cert	1 OSLANP		29c. Licens	e number 9797_	2	9d. Date signed (Monti	h, Day, Year)		
	クイ		30. Name and oddress of person	on who completed cause of dea	ith (Item 23a) (Type, F		TIMONIUM	MD 210	93			
	Stat Registra		31. Date filed AUG. Tyme	010 32. Registrar's	s Signature		1110111011	<u>, 2.10</u>				

DHMH 17 Rev 7/2009

Sheila Claudette Moore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2010 25564

		1- For State Registrar	Ce	ertificate c	of Death		Re	eg. No.	0 2330.
Physicia		1. Decedent's Name (First, Middle,Last					Date of Deat Month		3. Time of Death
ledical Exami	ner						July 25, 20	010	2351 hrs
ره		4a. Facility Name (if not institution, give Johns Hopkins Hospital	street and number)		4b. City, Tow Baltimor	n, or Location of De e	eath	4c. County of Dea	ath
Funeral Director				. last birthday) 52 yr	If Under 1 Months		Hrs. 8. Date of Bird	th(MM/DD/YYYY) 9. E /1958 Fore	Birthplace (State or eign MD Country)
any		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Loca	ation				10d. Inside City Limits
*	_	MD		ltimor					1 Yes 2 No
Aaryland 28a-f show 1 at once.	Director	10e. Street and Number	L		10f. Zip Co	de	10	Og. Citizen of What Co	ountry?
th the Maryland 23a or 28a-f sho		202 St. Matthe				21202		US	
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	by Funeral		12. Was Decedent Ever in Armed Forces? 1 Yes 2X No If Yes, Give Year or Dates:	If		of Hispanic Origin? uban, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	White, etc.	erican Indian, Black, lack
nours		15. Decedent's Education (Specify on	y highest grade completed)	16a. Decede	ent's Usual Occ	cupation (Give kind g life. DO NOT use	of work done	16b. Kind of Busines	
21215-0036 uld be filed within 72 l Mental Hygiene. marked other than " c event, the Nedical E	Completed	Elementary/Secondary (0-12) 1 2	College (1-4 or 5+)		her Ai			Baltimon Public S	_
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica		17. Father's Name (First, Middle, Last)		1			me (First, Middle, N		
121 d be fi ental arked	Be	Albert Moore	=2;==0				tie Joy		
D 21 should I and Met 7 is man	ို	19a. Informant's Name/Relationship (Ty Hattie Joyce	Mother	100				ber, City or Town, Sta	
mand 2 sho lealth and tem 27 is traumat		20a. Method of Disposition	206	. Place of Dispo	ST. IV	lattnews of cemetery.	ST Bal	timore, MI	21202 or Town, State
more, MD 2 Pages I and 2 shou ent of Health and I nut: If item 27 is n		1 Burial 2 Cremation 3 Donation 5 Other Specify:	Removal from State	arden	ther place)	•	/5/2010	Hanover	
Baltimore, MD 21215-00 pernit. Pages I and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other injury or other traumatic event, the Me.		21. Signature of Funeral Service Licens	ee	22.	Name and Add			A Weather	ford
Physician	-	23a. Part I. Enter the disease, or complete	cations that caused the dea	th. Do not enter	431 E	Oliver	st Ba	timore,	MT 21213 proximate Interval
/Medical	1	failure. List only one cause on ea	th line. Multiple Injuries			,5,	, , , , , , , , , , , , , , , , , , , ,	,,	Between Onset and Death
Examiner			Oue to (or as a consequence	of):					
		Sequentially list conditions, b.							
	nine	cause. Enter Underlying Cause	Oue to (or as a consequence	of):					
ansit	Examiner	(Uisease or injury that initiated events resulting in death) Last	Due to (or as a consequence	of):		-			
3760, ificate be executed g physician and s the burial - trans	n/Medical	UNPENDED	AMENDED						
	n/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pre		etal death	3 Ectopic pre	gnancy	23d. Date of delive	ery Day Year
Box 687 death certific the attending p	hysiciar	past 12 months? 1 Yes 2 No 9 V Unknown	4 Pregnant at time of	death	other (Specify)		grandy		24,
11 0 5 0	Phy	Part II. Other significant conditions	9 Unknown	resulting in the	underlying car	ise diven in Part I	23e Did to	bacco use contribute t	o the cause of death?
P.C es that	Š								obably 4 Unknown
Records, The law require frate has been si	Completed						24a. Was a	sy prior to	autopsy findings available o completion of cause of
Rec The la	E						perfor		pro-
tal Rection: The	Be	25. Was case referred to medical examiner?			26.F	Place of Death (Che	ck only one)		
of Vital ng Physician: After this certi	P	1 ✔ Yes 2 No		ER/Outpatier				Residence 6 Oth	er:
_ ≛ . ≦ . [Certification:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury Jul 25, 2010	28b. Time of 2247 hrs	Injury 28c.	Injury at Work? Yes 2 ✔ No		now injury occurred struck by minivan	ı
Division rate of a rate of	fica	2 Accident Investigation 3 Suicide 6 Could not be	28e Place of Injury - At	home, farm, stre	eet, factory, off	ice building, etc.	28f. Location (S	Street and Number or F	Rural Route Number, City
Divisior Hospital or Attend 24 hours after death Funeral Director:	팅	4 Homicide determined	(Specify) Local Stre	eet			or Town, S 800 Block of E	tate) Ensor Street, Baltim	ore, Md.
To the Hoss within 24 ha To the Fun completely	Medical (one) 2 V Medical Examiner:	n: To the best of my knowle On the basis of examination						
To To	Mec	29b. Signature and title of certifier	and manner stated.		29c. Lie	cense number		29d. Date signed (M	fonth, Da y , Year)
		anes 2			0	.C.M.E.		July 26, 2010	
	ŀ	30. Name and address of person who c	ompleted cause of death (Ite	em 23a)					
			t Medical Examiner			imore, MD 212	201		
St Regist		31. Date filed (Month, Day, Year)	32. Registraf's Igna	ature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give stre Examiner enue timore 8. Date of Birth Month, Day g. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🔀 F Director 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at items 23a or 28a-f shouner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 XYes 2 ☐ No imore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give 2 **X** No Completed by Maryland 21215-0036 1 ☐ Yes 2 XNo 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) /Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) မ mas 19b. Mailing Address (Street and Nun 19a. Informant's Name/Relationship (Type, Print) mmet Vicholson Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition ■ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee ationa Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause _____nch line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year 4 Pregnant a 5 Other (specify) Pregnant at time of death Yes signed by the at d be detached for 1 ☐ Yes ∠ □ 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Records, Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s performed 1 ☐ Yes 2 ☐ No this certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be Other: 2 No ၉ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 2 🗌 No 1 🗌 Yes 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License numbe 29b. Signature and title of certified

\5 Sta

State Registrar

DHMH 17 Rev 7/2009

(Item 23a) (Type, Print)

who completed cause

AUG 172010

of deg

32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens 25566 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ AUGUST 2010 FRED CHARLES PIRRERA 4:10 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE PICKERSGILL NURSING AND REHAB TOWSON Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Months Days Hours Min. JAN. 6, 1925 Director 85 MD 217-16-5205 Usual Residence of Decedent show 10a. State 10b. County the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2🏋 No BALTIMORE TOWSON MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 615 CHESNUT AVE 21204 USA Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces?

1 A Yes 2 No Black. White, etc 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE If Yes, Give 3 XWidowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) ANALYST OIL COMPANY 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 CHARLES PIRRERA CONSTANCE CRIMI other traumatic 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3008 BIRCHBROOK RD RICHMOND, VA 23228 KATHLEEN FOOTE-DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other places of FAITH 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 8/18/10 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) permit. 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC 21. Signature of Fun all Service Lice 6415 BELAIR RD BALTIMORE, MD 21206 23a, Part 1. Enter the disease fications that caused the death. Do not enter the mode of dying, such as cardiac or aspiratory ar Approximate Interval B tween shock, or heart failing Immediate Cause (Final Quest of the tree Physician/ disease or condition Medical resulting in death) equence of Examiner esease an efficient bell effective un-Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 the as IF FEMALE use yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Pregnant at time of death Month Day signed by the a Unknown Other significant conditions 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Tes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 24 hours after death.

Funeral Director: After this certificate has page 2 autopsy performed 2 🗆 No 1 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 1 🗌 Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work?
1 Yes 2 No Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

DHMH 17 Rev 7/2009

Registrar

29b. Signature and title of ce

ss of person who

(Item 23a) (Type, Print)

completed cause of death

License number

	•	State of Maryland / Dep State of Maryland / Dep Registrar Ce		lental Hygi	•	25567	
Physicia		1. Decedent's Name (First, Middle, Last) Walter J. Pasciak		2. Date of Death Month August	Îซ 2ัซิโ'o	3. Time of Death 12:00 Рм	
/Medic Examin		4a. Facility Name (If not institution, give street and number) Glen Meadows Retirement	4b. City, Town, or Location of Death		4c. County of Death		
Funeral Director		5. Social Security Number 101–16–9361 6. Sex 1 85 1 85 1 Security Number 101–16–9361 7. Age (In yrs. last birthday 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	/ If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, May 26,	1925 New	hplace (State or Foreign untry) York	
ne Maryland 8a-f show	ector	MD Baltimore Glen Ar	m			10d. Inside City Limits 1 □Yes 2X No	
th with th	Funeral Director	10e. Street and Number 11630 Glen Arm Road	10f. Zip Code 21057	10	g. Citizen of What Co USA	untry?	
be filed within 72 hours after death with the Maryland tal Hygiene. Ital Hygiene. d other than "natural", or Items 23a or 28a-f show event, It to modical Examination must be invited.	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 □ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 ☒ No Specify:	ecify Yes or No- Rican, etc.)	or No- 14. Race - American Indian Black, White, etc. Specify: White		
permit. Pages 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural"; or I any Injury or other traumatic event, It a modification one.	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) .rector	ing 10	6b. Kind of Business/l Big Brot Associat	hers	
wild be filed Mental Hyg arked other atic event,	To Be C	17. Father's Name (First, Middle, Last) Joseph Pasciak	18. Mother's Nam	e (First, Middle, Ma	aiden Surname) un	k	
and 2 sho salth and 27 Is m er traum			ling Address (Street and Number or Rui Concord Street; E			'ip Code)	
Pages 1 ament of He ant; If item ury or oth		4 \(\text{\text{Donation}}\) Donation 5 \(\text{\text{Other (Specify)}}\)	ematory`or other place)		Oc. Location - City or	rown, State	
permit Depart Import any Inj once,		21. Signature of Funeral Service Licensee Ronal d S wade Director	22. Name and Address of Facility Sta 655 W. Baltimore			MD 21201	
Physician /Medical		23a. Part 1. Enter the diseas of or contribution that caused the death. Do not e shoot, or heart failure. List only one cause on each line. Immediate Cause (Final disease or andition resulting in death)		or respiratory arres	st,	Approximate Interval Between Onset and Death	
te be executed ystcian and burial-transit	ical Ex	Immediate Cause (Final disease or a notition resulting in death) Source field list a notions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a dynsequence of): Due to (or as a consequence of): Due to (or as a consequence of):	y disease			years	
To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of deli Month	ivery Day Year	
quires that the de n signed by the a lid be detached to		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to	the cause of death?	
r: The law require icate has been signage 2 should b	Completed by	Chroni hidney disease		24a. Was an autopsy performe 1 □ Yes 2	prior to death?	topsy findings available completion of cause of	
Physician: The la r this certificate ha ral director, page 2	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	Other	n <i>(Check only one)</i> me 5 ☐ Residen	ce 6 Dother (Spec	Assisted wing	
To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After i completely filled in by the funera	Certification: To	27. Manner of Death 1	Mork? M 1 □Yes 2 □ No	28d. Describe how 28f. Location (Stre	eet and Number or Ru	ıral Route Number,	
ospital or hours afte ineral Dir		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	ath occurred at the time, date and place,	City or Town,	use(s) and manner as	stated.	
To the He within 24 To the Fu	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated. 29b. Signature and title of certifier	29c. License number	red at the time, dat	d. Date signed (Month	to the cause(s)	
)		30. Name and address of person who completed cause of death (Item 23a) (Type	1) 30 4 3 3	1	ng 10, 20	910	
Stat		M DAM MD CASMC 6761 N U 31. Date filed (Month, Day, Year) Registrar's Signature	ratus AU., Balle	more	14a 2120) 4	
Registra	ir	AUG 17 2010	Week				

	-	For State		State of N	1arylan		artment o			Mental Hy	0.4	010	25560	
		Registrar 1. Decedent's Name			<u> </u>				2. Date of Death Month Day Year 3. Time of Death			3. Time of Death		
Physician /Medica	ı	Hedwig	Hele				T.: -: -			Month	16 8	2010	1-30 A M	
Examine	r	4a. Facility Name <i>(If</i> Augsburg		ive street and numbe an Home					r Location of Death			4c. County of Death Baltimore		
Funeral		5. Social Security Number 6. Sex 7. Age				ast birthday)	If Under 1			8. Date of Bi	ate of Birth Month, Day, Year) 5-12-1915		Birthplace (State or Foreign Country)	
Director	}	217-66-4 Usual Residence of		1 □ M 2\CXF	95	Yrs.				03-12	-1915		MD	
ryland	. 1	10a. State	10b. County		1	y, Town or Lo		-					10d. Inside City Limits	
he Ma 28a-f s	ecto	MD 10e. Street and Num	Baltin	nore	Bal	timor	10f. Zip Co	-de			10s Citizan	of What Cou	1 ☐ Yes 2 🔀 No	
death with the Maryland ms 23a or 28a-f show Finust be nedified at	2	1007 Elmridge Ave.				21229					USA	or writer Cou	nu y :	
ite er	Dy Fu	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent 1 Armed Forces? 1 Yes, Give Year or Dates:			s?] No	If Yes, specify Cuban, Mexican, Pu						14. Race - American Indian, Black, White, etc. Specity: White		
15-(Siete	15. Decedent's Education (Specify only highest grade completed)				16a. Decedent's Usual Occupation (Give kind of work done during most of workil life. DO NOT use retired)					16b. Kind of Business/Industry			
212 d withi giene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+				Homemaker				Self-employed			yed	
be file had othe event.	e n	17. Father's Name (First, Middle, Last)								ne (First, Middle, Maiden Surname)				
Iryls should nd Mer marke matic	<u> </u>	William D. Hoffman Henrietta Schildwaechter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip										n Code)		
y Ma and 2 satth a n 27 is		Sharon Na		110 Howard Road, Stev										
Baltimore, Maryland 21215-0036 bermit. Pages 1 and 2 should be filed within 72 hours ath Department of Health and Mental Hygiene. mportant: If item 27 is marked other than "natural", or nny injury or other traumatic event, the Modical Expendance.		20a. Method of Disposition Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 ☐ Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place Loudon Park Cemete			1	Date 9/2010		on - City or T more,		
Balti permit. Departin Importa any Inju		21. Signature of Euneyal Service Licensee 22. Name and Address of Facility Bailey Funeral Home and Cremation Service, PA												
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one-gause on each line.												
Physician /Medical		Immediate Cause (Final disease or condition resulting in death) ATHEROSCIEPSTIC CARDIOVASCINAR DISEASE Onset and Death Onset and Death												
Examiner					as a consequ	uence of):						:		
sit ed	Se guentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):													
8760, sate be executed only sician and the burial-transit	Exam	that initiated events resulting in death) L		c. Due to (or a	s a consequence of):									
8760, cate be e	dical			d										
Box 6	Pnysician/Med	IF FEMALE: 23b. Was decedent in the past 12 r 1 □ Yes 2 9 □ Unknown	nonths?	23c. If yes, outcon 1 ☐ Live birth 4 ☐ Pregnan 9 ☐ Unknown	n 2 ☐ Fetal t at time of d	I death 3	⊒Ectopic preç ⊒Other <i>(sp</i> ec				23d.	Date of delive	very Day Year	
S, P	by Pr	Part II. Other signifi	cant conditions	contributing to death	but not resu	ulting in the u	nderlying caus	se given in	Part I.	23e. Did	tobacco use	contribute to	the cause of death?	
Records, he law requires the law seen signer to should be dignerated to should be dignerated.										1	Yes 2 N	lo 3∏Pro	bably 4 Unknown	
Rec	Сотріете									24a. Wa auto per	s an 2 opsy formed?	4b. Were aut prior to c death?	opsy findings available ompletion of cause of	
an: Than tifficate tor, pa	യ	25. Was case referre	ed to medical					26	Place of Dea	1 ☐ Yes	2 No	1 ☐ Yes	211No	
of Vi	0	examiner?		Hospital: 1 ☐ Inpa		ER/Outpatie	nt 3 🗆 DOA	Other: 4	_/	ome 5 ☐ Re		Other (Spec	ify)	
on of dlng Phys h. After this funeral dii	1001	27. Mann of Death 1 Natural 5 Pending (Month, Day, Year) 2 Natural investigation 2 Natural investigation M 1 Yes 2 No												
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that the de within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Certification;	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							2 🗔 140	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
lospital t hours a uneral I		29a. Certifier (Check only and due to the cause(s) and manner as stated. (Check only and Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)												
To the R within 2 To the R complete	Medica	one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (gned (Month	, Day, Year)			
	-	Jaskeen Vallan MI) D2895 8/16/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TASNEED AICHAM, 2835 SmITH AVE, SENTE 283, BACK										1		
17		TASNE	Em (AKCHAN	1, 5	1835 8	111 wes	+ A	E,S	eut E	283, K	AUD	MD 21209	
State Registra		31. Date filed (Monta		32. Regi	strar's Signa	ture	,							
DHMH 17 Rev 1/200		AUG I	1 2010		~ 19		LAIAI							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 03:38 AM Ritchey Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death University of Maryland Medical Center Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 9. Birthplace (State or Foreign Days Hours Min. 218-70-2079 1 🔀 M 2 🗆 F 55 Country) lo*8%*09%1955 Director MD Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo MD Frostburg Allegany 1 X Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 17301 Windcrest Lane 21532 Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Marital Status 14. Bace - American Indian. Armed Forces Black, White, etc. ģ 1 Never Married 2X Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White If Yes. Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 l h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Steel Worker Steel 12 æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Catherine Charles Ritchey Preston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s f Health item 27 Edith Ritchey / Spouse 17301 Windcrest Lane, Frostburg, MD 21532 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 8/16/2010 Final Journey Crem. Woodbine, MD 22. Name and Address of Facility
Maryland Cremation Services
Po Box 1413, Baltimore, MD 21. Signature of Funeral Service Licensee Dorrota Marshall Moushal 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. erval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition tensistent ventricular tachycordio Medical resulting in death) Due to (or as a consequence of): Examiner schemic cardiamyopathi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): 11 years intarctio Myocardial that initiated events Due to (or as a consequence of) resulting in death) Last sician a burial-Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 🗀 Live Birth 2 🗀 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 🗌 Yes 2 🗀 No Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 X No ည 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 2 🗌 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Division of Vital

State Registrar 29b. Signature and title of certif

Jenna Canzoniero, University of Magland Medical Center, 22 South Greene Street, Baltimore, MD 2120/ AUG 172010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1003135435

29d. Date signed (Month, Day, Year) August 11, 2010

Gertifying Nurse Prantianer: To the best of my knowledge, death occurred at the fixer, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month STEWART **Physician** LYDE LEE 2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death (If not institution, give street and number) **Examiner** HARbOR HOSDI N/A Baltimore 8. Date of Birth (Month, Day, Year)
Sept. 14,1949 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday, 5. Social Security Number **Funeral** Hours Min Months Days 1 ■ M 2 □ F Maryland 60 Director 214-54-9226 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examination ust be multihad at 1 ☐ Yes 2X No Director Anne Arundel Glen Burnie Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21061 U.S.A. 1203 Branch Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 X No altimore, Maryland 21215-0036 Specify Specify: White 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd 2 should be filed within alth and Mental Hygiene.
27 is marked other than College (1-4or 5+)
N/A Elementary/Secondary (0-12) Tool & Die Company Inspector 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Katie Clyde Stewart 2 19a. Informant's Name/Relationship (Type. Print)
Betty J. Higgins(Representative) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is n any injury or other traun once. 152 Riviera Drive Pasadena, Maryland 21122 Date 20c. Location - City or Town, State 20a. Method of Disposition
1 □ Burial 2 ☑ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 08/16/2010 Glen Burnie, Maryland Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) McCully—Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) NEUROENDOCRINE TUMOR 2 MONTHS METASTATIC Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Dise to (or as a consequence of) Examiner rany, leading to minisorial cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) cate has been signed by the page 2 should be detached in 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 🛣 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 🗖 No 1 ☐Yes 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After t 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Sharma, MD August 4 **RES 000**

10*1

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BALTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 1200 P Marie vances Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Dinai Hospita 3altimores 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 - M 2 X Months Days Hours 118.20.2096 Yrs. Director Usual Residence of Decedent 28a-f shov 10b. County than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Avenue bwanda 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 No Specify Specify: Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College, (1-4 or 5+) Cleuners Dresser 12th grade permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mrytle Hall Samuel W. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21244 19a. Informant's Name/Relationship (Type, Print) A. Johnson anter Hindon Circle Unit 303 Windsor Mill, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Baltimone, MD 4 ☐ Donation 5 ☐ Other (Specify) 08 2010 re of Funeral Service License C. Greene Flineral Services Fandallstown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition 411 Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Jause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 _ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death ed by the a detached f 1 Yes 2 D 9 Unknown signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Completed should should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an cate has autopsy performed Yes 2 After this certificate funeral director, pag 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 No 1 🗌 Yes မ 1 Inpatient 2 KER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No 1 Natural within 24 hours after death.

To the Funeral Director: Air completed filled in by the fu death. Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Si

07

AUG 17204

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20b, perFH, C906, 8/17/2010, WS
State of Maryland / Department of Health and Mental Hygien () | ()

amend items 20b,c per fh g906 8-31-10 years)

Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 M 2 D F Hours Director 216-34-565 Usual Residence of Deceden 06 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore NA 1 X Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5504 West North 21207 U.S.A Ave 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1.1 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc ģ 1 Never Married 2 Married 1 X Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than 12th grade College (1-4 or 5+) Crew Leader Lever Brother Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maron Sabb Lila King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Patricia Sabb-Wife <u>5504 West North Ave, Baltimore, </u> Md 21207 20a. Method of Disposition 20b. Place of Disposition (Name of the cemetery, crematory or other place) 20c. Location - City or Town, State Date Unk 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Owings Mills Garrison Forest 9-1-10 Baltimore, MD 21. Signature Auneral Service Licens March Address of Facility March Fr H West 4300 Wabash Ave, Md 21215 Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Overw mina disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Duri to for as a consequence ory If any leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by the funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performad udvation 1 Yes No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 မ 1 Tes Nο 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Dear 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No after death **A**ccident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours a Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifi 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State AUG 1 7 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar 25573 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ Pauline Saunders Month Day 8:55A 2010 Medical August 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Season's Hospice Randallstown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Hours 1 □ M 2**X** F Director 69 214-38-882] 28 Usual Residence of Decedent 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If ifew 27 is marked outher than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3916 West Cold Spring Lane 21215 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify. 3 Widowed 4 Divorced Completed Black Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade Nursing Private Duty Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Paul Saunders <u>Cecelia Ennels</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215 3916 West Cold Spring Lane, Baltimore, Md James L. Saunders-Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Druid Ridge 8/20/2010 Pikesville, Md Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Av Baltimore, 21215 . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death ediate Cause (Final Physician disease or condition resulting in death) COLON Cancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed ause (Disease or finjuly and use as the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial. Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown 9 Unknown the ins certificate has been signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 24 hours after death. Funeral Director; After this certificate has I autopsy performed? Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural 5 Pending injury 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 📝 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MSRajapakse, M.D 8/14/10 DOUS7465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD. 21209-·S. Rajapa Kse, M.D 31. Date filed (Month, Day, Year) 32. Registra 's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 19:36 PM Scott AUGUSTIZ Katherine Mae 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner St. Agnes Hospital Baltinoge M funder 1 Year I If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 □ M 2 👽 F Yrs 90 Director 215-12-0722 30 20 MD 07 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 28a-f show r than "natural", or items 23a or 28a-f shov the Wedical Examinar must be rediffed at Y□Yes 2 □ No Director NA Baltimore MD 10g. Citizen of What Country? 10e Street and Number 21229 U.S.A. Funeral 2201 Walbrook Ave Apt 307 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Wo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black δ 3 ☐ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Private Duty 12th grade 2yrs+ <u>Private Duty Nurse</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 nent of Health and Mental Harry R. Jackson Virgie Jackson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau Elderson Ave, Baltimore, Md 21215 4123 Gerald Williams-Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 8/19/2010 Arbutus Memorial Arbutus, Md 22. Name and Address of Facility
March F/H West 21. Sig tup of Funeral Service Licenses 4300 Wabash Ave, Baltimore, Md 21215 23a. P. rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death frequediate Cause (Final disease or condition resulting in death) Physician Parcreatic wonths Carcinoma /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the condition of the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 □No 2 🗆 No Vital Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA ပ Division of this Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28a 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Director: d in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral C ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Baltimore, maryland 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Saint 21229 32. Registra State Registrar

DHMH 17 Rev 1/2001

COTT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 9, Day 2010 Christine Stindt 1108 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F 10/9/1923 Germany 212-64-1844 Director 86 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director MD Silver Spring 1 Yes 2 No Montgomery 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13101 Hutchinson Way 20906 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 5 à 1 Never Married 2 Married Specify. White Baltimore, Maryland 21215-0036 1 Yes 2 No 3X Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 in and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Nurse Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Leah Stindt Richard Myron 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13101 Hutchinson Way Silver Spring MD 20906 permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau Madeleine Sellouk - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Judean Mem. Gardens 08/12/2010 Olney, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Edward Sagel Funeral Direction 1091 Rockville Pike Rockville MD 20852 21. Signature of Funeral Service Licenses M001163 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Hypercapnic Respiratory Failure Medical Due to (or as a consequence of) Examiner Chronic Obstructive Pulmonary Disease Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Examiner Due to (or as a consequence on). sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the nse s, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed dementia, bicuspid aortic valve 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe death? certificate 1 ☐ Yes 2 🗷 No 25. Was case referred to medica æ 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 No 2 1 ♣ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation Director: 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined hours after City or Town, State) within 24 hours a

To the Funeral C

completed filled Medical 29a Certifier Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0065485 Supanich. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barbara Ann Supanich MD 1500 Forest Glen Road Silver Spring MD 20910 31. Date filed (Month. Dav. Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 08 Day Physician/ KETTY 0845 AM SHIPE 10 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death JOHNS HOPKINS BAYVIEW MEDICAL (ENTE RALTIMORE BALTIMORE CITY If Under 1 Year If Under 24 Hrs.

Pays Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2527 Months (Month, Day, Year, Virginia 226-32-846 Director 82 1928 1.1 Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director RALTIMORE 1 Ses 2 □ No MD BALTIMORE CITY 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21211 AVENUE S.A 3316 FLM items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. ō Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE "natural", 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 12 Cook Tangiers Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Nina Cunningham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 919 Mine Mountain Lane Port Valley, VA <u>Garland M. Shipe</u> Son 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 😾 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Lake View Mem. Park 8/17/10 Sykesville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road ren ELINE FUNERAL HOME Reisterstown, MD 21136 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final +hysician MULTIORGAN FAILURE disease or condition 12 hrs Medical resulting in death) Due to (or as a consequence of): Examiner 20 hrs BURN -1ATUR Sequentially list conditions, if any, leading a immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of CERTIFICATION APPROVED BY MEDICAL EXAMINER The law requires that the death certificate be executed sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 as the IE EEMALE use yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months? Month 5 Other (specify) Pregnant at time of death ed by the a Yes 2500 9 Unknown 9 Unknown P.O. signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 1 Yes 2 No Yes 2 No Division of Vital or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be examiner? 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No 2 1 patient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 5 Pending ☐ Natural Accident 08,09,10 45 1 Yes HOUSE FIRE death Investigation within 24 hours after deat To the Funeral Director: 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) HOME ELH Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check the 29b. Signature and title of pertifier 29d. Date signed (Month, Day, Year) DES-000 2010 30. Name and address of percon who completed cause of death (Item 23a) (Type, Print) EASTERN ALFREDO CORDOVA 4940 AVENUE BALTIMORE 21227 MD 31. Date filed (Month, Day, Yea 32. Registrar's Signature State MALLA Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 1^{Day} Physician/ 2010 Margaret Eleanora Stevens <u>August</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 815 Winters Lane Apt.310 Catonsville If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 X F Hours oct 30, ^{^e}1917 Marviand 92 Yrs 216-03-3112 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10b. County 10c. City, Town or Location 10a. State death with the Maryland "natural", or items 23a or 28a-f sho Director 1 Tes 2 No Maryland Baltimore Catonsville 10g. Citizen of What Country? 10e, Street and Number Funeral 815 Winters Lane Apt.310 21228 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? 1 X Yes 2 □ No 1943 Black, White, etc. 1 X Never Married 2 Married þ Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. Specify: White 3 Widowed 4 Divorced Completed 1945 permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical sonce. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) Private Company 11 Secretary Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nora Chamberlain Alexander Stevens 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 205 School Lane Linthicum Heights, Maryland 21090 Dennis Stevens, Nephew 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Metro Crematory Inc. 08/17/10 Baltimore, Maryland 4 Donation 5 Other (Specify) Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21. Signature of Funeral Service Lice (see Thomas Gregor homo 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final THE ROSCIEROU CARDIOVASCULAR Physician/ 1 FAR disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Dus to (or es e consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year Month 1 ☐ Yes 2 ☐ Unknown been signed by the s should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown MELLITUS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed 1 Yes 2 No this certificate Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) B Hospital: Other: 1 ☐ Yes 2 ☑ No 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospital within 24 hours To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title August 16th 2010 asantha (cumin mp address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

ack

·VASAN-EUALCUMAN, MD

AUG 172010

32. Registrar

516. N ROLLING RD # 108,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 25578 State of Maryland / Department of Health and Mental Hygiene 1 1 - State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 2010 August 8:00a Phyllis J. Seman Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel 8425 Lockwood Road Pasadena g. Birthplace (State or Foreign 8. Date of Birth Social Security Number Age (In yrs. last birthday) Year If Under **Funeral** Maryland Dec. 4, 1938 Months Hours Min. 1 M 2 X F 212-36-1414 71 Director Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland Director 1 Yes 2 No Maryland Arundel Pasadena Anne 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code ö "natural", or items 23a o Funeral 21122 United States 8425 Lockwood Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11, Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify. White 3 ☐ Widowed 4 ☐ Divorced Completed Page 1 and 2 should be filed with the firm of leath and Mental Hygiene. Tant: If item 27 is marked other than "natur martic event, the Medical.] 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Transportation Truck Driver Be 18. Mother's Name (First, Middle, Maiden Surname) unk unk 17. Father's Name (First, Middle, Last) David Robert Merrill 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Deborah Whalen, Daughter 8425 Lockwood Road, Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1. Department of I Important: If it any injury or or 1 Durial 2 Cremation 3 Removal from State 8/16/2010_ Metro Crematory, Inc. Baltimore, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facilit Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final d Hysician くせいころ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury ng physician and as the burial-transit The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 attending properties for use as IF FEMALE: Live Birth 2 Fetal death 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month the a g 🗌 Unknown Records, P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? signed to þ 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has certificate 1 Yes Yes 2 V No 26. Place of Death (Check only one) 25. Was case referred to medica Be examiner? Other: 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) မှ this in by the funeral 28a. Date of injury 28b. Time of 28c. Injury at work? 27. Manner of Death 28d. Describe how injury occurred Certificate: Director; After Natural (Month, Day, Year) 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined

the Hospital or Attending Physician: Division of Vital n 24 hours after in Funeral Direc

State Registrar DHMH 17 Rev 7/2009

completed filled

within 2

Medical

29a. Certifier

29b. Signature and title of cortili

30. Name and address of person who

Date filed (Month, Day, Year)

AUG

eted cause of death (Item 23a) (Type, Print)

Registrar's Signal

seem.

**Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

City or Town, State)

DHMH 17 Rev 1/2001

State Registrar DUSDUL #203 BOLFINONS, NOW / DNS 21209

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SiAM my

31. Date filed (Month, Day, Year)

2835 Smins

32. Registrar Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 25580 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Physician/ Donna Saunders August 16 a^{M} 4:32 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1859 Foxwood Circle PG Mitchellville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 578-92-6491 1 M 2 X F Days Hours Min Wash. DC 48 Yrs Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director MD PG Upper Marlboro 1 X Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 4446 Swindon Terrace 20772 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: "natural" 3 Widowed 4 Divorced Black the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) Kastle Systems Int'l Human Resource Management traumatic event, Be permit. Page 1 and 2 should be filec Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic even once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ George Saunders Marie Rose VanHook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1859 Foxwood Circle Mitchellville, MD 20721 Rodney Ramsour/Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Ft. Lincoln Cemetery 8-20-10 Brentwood, MD 4 Donation 5 Other (Specify) 2. Signature of Fineral Service License 22. Name and Address of Facility Ronald Taylor II FH 10583 Middleport Ln. White Plains, MD 20695 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician Breast Cancer Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): sician and burial-transit Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 1 ☐ Yes 2 💆 No Month Day Year n signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Hunknown nours after death.

eral Director: After this certificate has been si filled in by the funeral director, page 2 should I Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 1 2**X** No 1 🗌 Yes 25. Was case referred to medical examiner?

↑ Yes 2 No 26. Place of Death (Check only one) Other: မ ER/Outpatient 3 DOA 1 Inpatient 2 I 4 Nursing Home 5 Residence 6 Other (Sp. 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 29c. License number 29d. Date signed (Month, Day, Year) stlew. Orano D23743 08-17-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 525 Greenway Ctr. Martin Weltz Dr. Greenbelt, MD 20770

Registrar

Please Type or Print in Black Indellble Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25581 Certificate of Death Reg. No. 2. Date of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) August 8,2010 1444P James Leroy Smith 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Ba1to. 11959 Philadelphia Road Kingsville If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 9. Birthplace (Stete or Foreign 5. Social Security Number Days 1 □ M 2 □ F Maryland Months Yrs. 53 219-70-2022 Usuel Residence of Decedent 10d. Inside City Limits 10a. Stete 10b. County 10c. City, Town or Location 1 ☐ Yes X ☐ No Kingsville Balto. 10e. Street end Number 10g. Citizen of What Country? USA 11957 Philadelphia Road 21087 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Merried 2 Married 1 ☐ Yes 2√ No Specify: Specify:White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Furniture Repair 10th Handyman 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nellie Klosterman Harold C. Plummer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Littlestown, Pa. 17340 197 S. Columbus Avenue Gary Plummer Bro. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-12-2010 Baltimore, Md. Bayview 21. Signature of Funda Service Linuse 22. Name and Address of Facility Schimunek Funeral Home Nottingham, Md. 21236 9705 Belair Road Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Ceuse (Final disease or condition resulting in deeth) Due to (or as a consequence of) Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events Due to (or es e consequence of): e contribute to the cause of death?

Physician /Medical Examiner

permit. Pages 1 and 2 should be file Department of Haatth and Mental Hy Important: If Itam 27 ia marked oth any Injury or other traumatic event

Physician

/Medical

Examiner

Director

Funeral

þ

Be Completed

Funeral

Director

6

4447

Smith 68/68/2010

Examiner Physician/Medical ours affer death.

ours affer death.

earal Director: After this certificate has been signed by the attending physic
filled in by the funeral director, page 2 should be detached for use as the f þ Be Completed Certification: To To the Hospital o within 24 hours at To the Funeral D completely filled i Medical

Division of Vital Records, P.O. Box 68760.

resulting in death) Last	d	or as a consequence oi).		
Part II. Other significant conditions	contributing to death but not res	ulting in the underlying caus	e given in Part I.	23b. Did tobacco us
				24a. Wes en eutopsy performed?
				1 Yes 2
5. Was case referred to medical			26. Place of De	ath (Check only one)
examiner? 1X Yes 2 □ No	Hospital: 1 Inpatient 2	ER/Outpatient 3□ DOA	Other: 4 Nursing H	Home 5 ☐ Residence 6
7. Manner of Death 1 □ Natural 5 □ Pending	28a. Dete of Injury (Month, Dey Year)	28b. Time of lnjury 28c.	Injury et Work?	28d. Describe how injury of

3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No KOther (Specify) STOVE occurred Selt inflicted gunshot wound AUGUST 8,2010 11444PM 1 ☐ Yes 2 No investigation □ Accident 28f. Location (Street and Number or Bural Route Number, City or Town, State) 1/459 Ph. 1901 hig Ro 6 Could not be determined 3 Suicide 14 ☐ Homicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) Antique Stove white Mand, Md 2116 29a. Certifier 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature end title of certifier 29c. License number D18667 August 9,2010 Hill CT. Latherville, Md 21093 mette No 30. Name and address of person who completed cause on deeth (Item 23e) (Type, Print) 31. Dete filed (Mooth, Day, Year) 32. Registrer's Signature 1 17

State Registrar

DHMH 16 Rev 6/95

ō

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25582 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2010 Dorothy M. Shilow August 5:00A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 315 Cleardrop Way Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov • 17, 1924 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 1 F Days Min. Months Hours Maryland 213-20-1972 Nov. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits show 10a, State event, the Medical Examinar must be notified at Director 1 ☐ Yes 2 ☑ No MD. Anne Arundel Glen Burnie 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 315 Cleardrop Way 21060 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status 1 Never Married 2 Married ٥, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: Specify: \$ 3 Widowed 4 Divorced Year or Dates 'natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Own Home Homemaker marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be 1 Health and Mental William Klender Anna Walters 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 is r permit. Pages 1 and Department of Health Important: If item 27 any injury or other tronce. Elmer J. Shilow / Husband 315 Cleardrop Way, Glen Burnie, Maryland 21060 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Meadowridge Mem. Park Aug. 14,2010 Elkridge, Maryland 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice AMBROSE FUNERALITYHOME OF LANSDOWNE allier aux 2719 Hammonds Ferry RD., Lansdowne, Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CREBROURSC **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner CARS Sequentially list or different if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 mor Dav 5 Other (specify) P.O. the detached 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe certificate COARTHRITUS 2 No 2 2 1 □ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending To the ruceprocess within 24 hours after death.

To the Funeral Director: Af 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

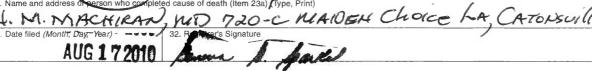
2

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who



pleted cause of death (Item 23a) Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Reg. No. 20 25583 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 26,2010 Larry Schumate 7:45 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Manor Care Nursing Home Towson Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Months Days Hours Min. 218-72-5478 1 M 2 □ F 55 MD 10/1955 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Conkling Street 21224 339 S. USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐**X**o If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 ☐ Married White 1 ☐Yes 2 【XNo Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Food - Meat Packing Handler 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Shumate unkn. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

509 E. Joppa Road, Towson, MD 21286

Waltham woods load MA21236

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evarinar must be notified at once.

Baltimore, Maryland 21215-0036

/Medical

10a State

Director

Funeral

ğ

Completed

Be (

ပ

MD

Larry Shumate / Self

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

gg a cate has page 2 s

Hospital or Attending Physician: The law requires that the death certificate be execute Division of Vital Records, P.O. Box 68760,

Examine Medical Certification: To Be Completed by Physician/Medical

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place	Date	20c. Location - City or	Town, State
1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Final Journey Cre		Woodbine,	MD
21. Signature of Funeral Service Licensee Dorota M	II Mary	s of Facility Land Crematic Ox 1413, Balt	n Services imore, MD	21203
23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	ne death. Do not enter the mode of dyin	g, such as cardiac or respiratory	arrest,	Approximate Interval Between
Immediate Cause (Final disease or condition	monic Nursham	one heukenn	3	Onset and Death
resulting in death) Due to (or as a death)	consequence of):			
cause. Enter Underlying Cause (Disease or injury that initiated events	consequence of):			
d			ŀ	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti	Fetal death 3 Ectopic pregnancy		23d. Date of del Month	ivery Day Year
Part II. Other significant conditions contributing to death but	not resulting in the underlying cause give		tobacco use contribute to Yes 2 ☐ No 3 ☐ Pr	/
		24a. Wa: auto perl 1 ∐Yes	opsy prior to death?	topsy findings available completion of cause of
25. Was case referred to medical examiner?		26. Place of Death (Check only	one)	
	2 ☐ ER/Outpatient 3 ☐ DOA Othe	r: 4 Nursing Home 5 ☐ Res	idence 6 ☐ Other (Spe	cify)
27. Man of of Death 1 Natural 5 Pending (Month, Day, 1) 2 Accident investigation	Year) Injury Work	rat 28d. Describe ? ′es 2 □ No	how injury occurred	
3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury building, etc.	- At home, farm, street, factory, office (Specify)	28f. Location City or To	(Street and Number or Ru wn, State)	ıral Route Number,
29a. Certifier (Check only one) Certifying Physician: To the best of 2 Medical Examiner: On the basis of e and manner state	xamination and/or investigation, in my or	ne, date and place, and due to the pinion, death occurred at the time	e cause(s) and manner as , date and place, and due	s stated. to the cause(s)
29b. Signature and title of certifier	29c. License	number	29d. Date signed (Monti	h, Day, Year)
MM MD	10573	127	07/20/1.	0

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day

AUG 172010

within 24 hours after death

To the Funeral Director:
completely filled in by the t

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 08 09 Mamie L Spriggs 2010 4:07 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Montgomery Spring If Under 24 Hrs. Spring Brook Nursing and Rehab Silver Age (In yrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) 03 24 1921 1 M 2 F Months Days Hours 578-32-3608 89 Director DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director 28a-f MD Montgomery Silver Spring 1 X Yes 2 □ No 10e, Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 12325 New Hampshire Ave USA 20904 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc ò þ 1 Never Married 2 Married 2 X No ☐ Yes Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes XX No Specify: Specify: Black "natural" 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. National Bureau of Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant 12th Standards permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other i any injury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George Mitchell Eunice Mobley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1813 Green Valley Lane Rocky Mount, NC 27804 Brenda Shields/niece 20b. Place of Disposition (Name of cemetery, crematory or other place, Md National Cem. 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 08/13/2010 Laurel, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall March Funeral Home 4217 9th ST NW Washington, DC 20011 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Senile Dementia, Advanced disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) g physician and as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical that the death certificate be attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Day Year 2 👚 No the ; 9 Unknown 9 Unknown as been signed by 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' certificate ! Yes 2 K No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 X No Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA ₩X Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at Hospital or Attending 1 X Natural 5 Pending injury hours after death.

neral Director: After tilled in by the fun 1 Yes 2 No 2 Accident
3 Suicide Investigation M 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined in 24 hours
to the Funeral Diccompleted filler Medical 29a. Certifier 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Cortifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year)

Box 68760

P.O.

Records,

Division of Vital

Registrar

Peter M Schissler MD 7500 Greenway Center Dr Greenbelt, MD 20770 31. Date filed (Month, Day, Year, 32. Registrar's Signature AUG 1 7 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D22780

08/12/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #18 Per FH G906 8/18/2010 The Health and Mental Hygiene 25585 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death raile **Physician** 13-21 PM August 2010 /Medical ndt institution, give street and 4c. County of Deal Examiner yrs last birthday) If Under 1 Year **Funeral** Months Days Hours **Director** Usual Residence of Decedent 10a. 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at t_i Director 1 Pres 2 No 10f. Zip Code 10g. Citizen of What Countr ō items 23a Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No Specify: <u>ک</u> 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, no NOT asprafired) than College (1-4or 5+) Department of Health and Mental Hygien Important: If item 27 is marked other tha any injury or other traumatic events. 'à Be of Disposition 20a. Met Burial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) ture of Funeral Service License Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death cardiac or respiratory arrest. Immediate Cause (Final **Physician** 040 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Edema Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or Attending Physician: The law requires that the death certificate be executed the attending physician and the for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Dav Year 5 ☐ Other (specify) 9 ☐ Unknown Š s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an certificate has page 2 1 ☐ Yes 2 **X** No completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\sum \) Nursing Home 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA After this Certification: To 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Deat 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No after death 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide within 24 hours 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certific Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) f person wh State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Clara E. Tufts 2010 8:10 A /Medical August 14, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Heartlands Assisted Living Severna Park Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2/CXF Hours 199-10-9882 Director 11/12/1914 West Virginia Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show event, the Medical Examiner must be notified at 1 □Yes 2 ₩ No Director MD Anne Arundel Severna Park 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 items 23a Funeral 715 Benfield Blvd Apt 219 21146 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 than "natural", or 1 □Yes 2 No Specify: ģ Specify: White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important; If Item 27 is marked other the any injury or other traumation. Crossing Guard Law Enforcement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Dudley Butler Clara Crosby 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Richard Tufts / Son 2830 Duvall Road Woodbine, MD 21797 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 19 4 ☐ Donation 5 ☐Other (Specify) 2010 Glen Haven Mem. Park Glen Burnie, MD 21. Signat en Funer I Service Licensee 22. Name and Address of Facility $Singleton\ Funeral\ \&\ Cremation$ Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 M01220 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** days preumonia disease or condition resulting in death) /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate an Entrangement Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): requires that the death certificate be executed Due to (or as a consequence of) burial attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregn 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 mod 1 ☐ Yes 2 ☐ No Day 4 ☐ Pregnant at time of death signed by the a P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform certificate Vital 1 □ Yes 2 No director 25. Was case referred to medical examiner? Be assisted 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To of After this funeral c 28a. Date of Injury (Month, Day, Year) 27. Manner Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 1 Unatural 5 Pending n 24 hours after death.

e Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

completely

within 2

Medical

(Check only one)

and title of certifie

29b. Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Roman Tanta 1137 08 2010 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death **Examiner** 4c. County of Death University of Many Battimore Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) 10/14/1932 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ★ M 2 □ F 059-44-7240 77 Philippines **Director** Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director FL Flagler Palm Coast 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 32164 5 Crandon Court Funeral 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Asian If Yes, Give Completed 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Airlines/Travel Stock Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Augustina Patdo ပ Esteban Tantay 19a. Informant's Name/Relationship (Type, Print)
Rowy Bohlen / Daughter 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State Zip Code) 5 Crandon Court, Palm Coast, FL 32164 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Final Journey Crem. 8/16/2010 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Dorota Marshall 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ traumatic praun wyon disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** 10 days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) that initiated events Hospital or Attending Physician: The law requires that the death certificate be exect resulting in death) Last Due to (or as a consequence of) Certificate: To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Pregnant at time of death Day Year 1 Yes 2 9 Unknown ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 2 No Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 X Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 XNo ☐ Natura! 5 Pending 0910 M MVC, car vs. toll booth 08.04.10 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc (Specify) 1 booth 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) R107416 14 August 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

31. Date filed (Month, Day, Year) AUG 1 7 2010 tuent

S. Greene

22

Baltmore, WD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 11:35 A.M Theodore Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Health Center TWASHINGTON 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 9. Birthplace State or Foreign Country) **Funeral** 1 M 2 F Days 081267722 Director Usual Residence of Decedent or 28a-f shov 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 Yes 2 No dor 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? rolling Meada SA $\Omega(\omega)$ 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes : 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elmhurst Elementary/Seconday (0-12) College (1-4 or 5+) REGISTER General Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည nomas arnes 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other tra 504 Danville 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 📈 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) outland, Mi edar 14:11 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 420 H Home Wash, DC, 20002 HEnr M01178 23a. Part 1. 27 er the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ 0 disease or condition Medical resulting in death) as a consequence of) **Examiner** 9 c ... Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical signed by the attending p d be detached for use as i IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 1 ☐ Yes 2 ♥ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has Hypotheyordes performed Yes 2 No 1 Yes 25. Was case referred to medical To the Hospital or Attending Physician; Be 26. Place of Death (Check only one) examiner? Other: 1 Tes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural

Accident work? 5 Pending 2 🗌 No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature title of certifie D42955 30. Name and address of person who completed use of death (Item 23a) (Type, Print) IDV 1201 Wash. 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Box 68760

Division of Vital

0-06032		Please Type or Prin							
Rennard Vernoi	n Th		ryland / Depa			nd Mental H	ygiene	2010	25589
		1- For State Registrar	Cei	rtificate	of Death		Re	eg. No.	
Physici	an/	Decedent's Name (First, Middle,Last)					Date of Deat Month		3. Time of Death
Medical Exam	iner	Rennard V,	Thompso	on			August 11		1555 hrs
		4a. Facility Name (if not institution, give street an	d number)		4b. City, Town, o	or Location of Death	1	4c. County of Death	
		3118 82nd Avenue			Landover			Prince George	e's
Funeral		Social Security Number	7. Age (In yrs. I	ast birthday	/) If Under 1 Ye	ar If Under 24Hr	8. Date of Birt	h(MM/DD/YYYY) 9. Bir	
Director		219-84-3204 XM 2	10		Yrs. Months Da	ys Hours Mir		Foreig	
		219-84-3204 11 M 2 Usual Residence of Decedent	^F 48		113.		March	271962 B	Ttimor M
any		10a. State 10b. County	10c. City,	Town or L	ocation			· · · · · · · · · · · · · · · · · · ·	10d. Inside City Limits
*		W1 5							1 Yes 2 No
yland I-f show	Director	Md. Prince Geo	rges Gr	eenb	elt 10f. Zip Code		120	g. Citizen of What Cour	
Mar r 28,	irec	ACTURE AND					11	g. Citizen of what Cour	ntry?
2 2 hours after death with the Maryland n "natural", or items 23a or 28a-f sho al Examiner must be nolified at once		7708 Hanover Park			20770	0		U.S.A.	
h wi	Funeral		Decedent Ever in U. ed Forces?	.S. 13.	Was Decedent of H If Yes, specify Cuba			14. Race - Ameri White, etc.	can Indian, Black,
deat or it	ä	1 Y	es 2 X No				radan, otoly		_
after	by I	Widowed 4 Divorced If Yes, Give or Dates:		1	Yes 2X N	o s <i>pecify:</i>		Specify: Bla	ıck
nours natur	pe	15. Decedent's Education (Specify only highest			edent's Usual Occupa g most of working life			16b. Kind of Business/I	ndustry
6 . 72 l	Completed	Elementary/Secondary (0-12) College	ge (1-4 or 5+)	-	g meet et nemmig in	0. 00 110 1 000 100	100)		
vithir ene.	E	12		D	isabilit	ty		Disabili	.tv
5-C		17. Father's Name (First, Middle, Last)				18.Mother's Name	(First, Middle, M	laiden Surname)	•
21215-0036 vild be filed within 72 hours afte Mental Hygiene. marked other than "natural", ic event, the Medical Examiner	Be	Vernon Green	e			Caro	Lyn W.	King	
	မ	19a. Informant's Name/Relationship (Type, Print)		19b. Ma	iling Address (Stre	et and Number or I	Rural Route Num	ber, City or Town, State	Zip Code)
imore, MD 2 Pages 1 and 2 shoument of Health and Nant: If item 27 is no or other traumatic		Carolyn Foxx		770	8 Hanove	er Parkv	vay, Gre	enbelt, Mc	1.20770
ore, MI ss 1 and 2 s of Health a If item 27 her traum:		20a. Method of Disposition		Place of Dis	sposition (Name of cor or other place)	emetery,	Date	20c. Location - City or	Town, State
Baltimore, permit. Pages 1 at Department of Hee Important: If ite		1 Burial 2 X Cremation 3 Remov	al IIOIII State	•	Cremator	077	4-10	Cotonari	llo Md
ii. Partme		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee				ss of Facility	4-10	Catonsvi	.rre, Mu.
Baltimore permit. Pages 1 Department of H Important: If i		Lly Dm Pa	100	E	step_Bro	others I	uneral	Ser, P.A.	
Physician	0 60	21. Signature of Funeral Service Licensee 23a. Part I. Enter the disease, or complications the	at caused the death	Do not ent	er the mode of dving	AW PIA.CE	<u>Balti</u>	more, Md. 2	1217 Approximate Interval
/Medical	3 33	failure. List only one cause on each line.				,,	, respiratory sairs	on, one on, or mount	Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)							Death
		- 200 10 (01	as a consequence of ion of Duodenal						
	<u>~</u>	Sequentially list conditions,	as a consequence of						
	Examiner	cause: Enter Underlying Cause	as a consequence of	7.				.179	i
	xan		as a consequence of):					
executed in and il - transi	Щ	d							
	lical	UNPENDED AMENDE	ED .						-
60 ate b	Physician/Med	IF FEMALE: 23c. If y	es, outcome of pregr	nancy				23d. Date of delivery	
587 artific ling p	an/	23b. Was decedent pregnant in the past 12 months?	ve birth	2	Fetal death 3	Ectopic pregna	ncy	Month D	ay Year
OX (eath ce ather for use	sici	1 Vac 3 No 0 Ulakasur 4 Pr	egnant at time of dea	ath 5	Other (Specify)			1	
B B B B B B B B B B B B B B B B B B B	ج		nknown						
ed by	by F	Part II. Other significant conditions contributing	ng to death but not re	sulting in t	ne underlying cause	given in Part I.		pacco use contribute to t	
rds, P.C	D D						1Yes	2 No 3 Prob	ably 4 🗸 Unknown
ords, w requires been should	Completed						24a. Was a autops		opsy findings available impletion of cause of
e law	티				·		perform	ned? death?	
tal Rectian: The certificate ector, page		25. Was case referred to medical			00.01		1 ✓ Yes 2	No 1 ✓ Ye	s 2 No
n of Vital Recing Physician: The land After this certificate land director, page	a	examiner? Hospital:	7 (FD/0-44		e of Death (Check of Other Nursin) i a a	
f Vi Physi er this	의	1 ✓ Yes 2 No 1 28a. D	Inpatient 2	ER/Outpati 28b. Time				Residence 6 V Other:	Scene
n of ding Pl	Ë	1 Notural - (M	onth, Day, Year)	ZOD. TIME		ury at Work? Yes 2 No	200. Describe no	ow injury occurred	
isior Attenc r death rector: by the	äŧ	2 Accident Investigation							
or A after Dire	ertificati	Suicide Could not be	Place of Injury - At ho	me, farm, s	treet, factory, office t	building, etc.	28f. Location (St or Town, Sta	reet and Number or Rur	al Route Number, City
pital lours lours filled	Š	4 Homicide determined (Spec	rify)						
t Ho: 24 h		29a. Certifier 1 Certifying Physician: To the							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Medical	one) 2 Medical Examiner; On the base	sis of examination an er stated.	nd/or invest	gation, in my opinior	n, death occurred a	t the time, date a	nd place, and due to the	cause(s)
H × H Z	ž	29b. Signature and title of certifier	<u></u>		29c. Licens	se number		29d. Date signed (Mon	th, Day, Year)
		Mhla h. II II			O.C.	M.E.		August 12, 2010	
.\	ļ	30. Name and address of person who completed of	cause of death (Item	23a)					
HV			Medical Examin	,	Penn Street, E	Baltimore. MD	21201		
\ V	ate					-,			
Regist		AUG 1 7 2010	we d.	far					
								· · · · · · · · · · · · · · · · · · ·	

DHMH 17 Rev 1/2001

OGME

ORIGINAL

			1 - For State Registrar	State of Maryland		tment of H ificate of L		d Mental Hy	/giene	0 2	25590
	Physic	ian	Decedent's Name (First, Middle, Las	ot)				2. Date of D Month	Day	Yeer	3. Time of Death
	/Medi Examii	cal	4a. Facility Name (If not institution, give	street and number)	-	4b. City, Town, or	Location of De	ath nogus	4c. County	of Death	5 Jya M
	Exami	ier		los noted Cen		20-1-11			Back		_
Ī	Funeral Director	0	5. Social Security Number 6. Security Number 6. Security Number 7. Sec		ast birthday)	If Under 1 Year Months Days	II Under 24 H	frs. 8. Date of B lin. Aug.	irth	9. Birthpl	ace (State or Foreign
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Loca	ation				10	Od. Inside City Limits
	with the Marylan s or 28e-f show be natified at	tor	mo NA	Balt	timore						1 Yes 2 No
	or 28	Funeral Director	10e. Street and Number	•		10f. Zip Code	_		10g. Citizen of W	hat Count	try?
	e 23a	eral	3919 W. Rogers	12. Was Decedent Ever in U.S	12.14	21215		(Carata Van and	USA	America	a ladia
36	72 hours after death with the Maryland natural; or Iteme 23a or 28e-f show dical Examinar must be notilised at	by Fun	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces? 1 Tyes 2 No If Yes, Give Year or Dates:	lf Y	Yes 2 No	spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or Nerto Rican, etc.)	Black Specify:	- America k, White, e	
9-0	"natural"		15. Decedent's Ed	ucation	16a. Deceder	nt's Usual Occupa	ition		16b. Kind of Bu		
Maryland 21215-0036	C 06	Completed	(Specify only highest gra	College (1-4or 5+)	Corper	nd of work done of NOT use retired,	uring most of t	working	Building		
Da.	2 should be filed within and Mental Hygiene. is marked other than aumatic event, I'm M	BeC	17. Father's Name (First, Middle, Last)			10/1	18. Mother's f	Name (First, Middle	a, Maiden Suman)	
yla	ould be Mental narked o		unk.			k	MIlis	le			
	s 1 and 2 should f Health and Mer frem 27 is marke other traumatic		19a. Informant's Name/Relationship (7	Dighter	5 by	A.	-	A Owing	ber, City or Town,	1122	Code)
Baltimore,	00		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State		tion (Name of tory or other place	9)	Date	20c. Location -	*	wn, State
altin	permit. Pag Depertment Important: f any injury o		Donation 5 Other (Specify 21. Signature defuneral Service Licen	11/11/	o lineu	Name and Addres		10-10 al Home	Randalle	TOWN	, YTIO
	205 4 9		23a. Part. Enleythe disease, or comp	plications that caused the death.	27	o Fredhi	Iton to	ss box		1239	Approximate
7.	Physician		shock/or beart lailure. List only of Immediate Cause (Final disease or condition	one cause on each line.							Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	ence ol):	~ 0.	- t ~ .	Mers			
		er	Sequentially list conditions,	b. Due to for as a consult	erice of):						
	and I-transit	Examiner	Cause (Disease or injury that initiated events	c.							
8760,	be exician	ilcal Ex	resulting in death) Last	Due to (or as a consequent	ence of):						
9	certificate iding physise as the		IF FEMALE:								
P.O. Box	atter for u	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal of the 4 ☐ Pregnant all time of dead of the fetal of the fet	death 3 □E	ctopic pregnancy Other (specify)			23d. Date Mor	of deliver	ry Day Year
	s that the do ned by the e detached	by Ph	Part II. Other significant conditions co	onInbuting Io death but not resul	lling in the und	erlying cause give	n in Part I.	23e. Did	tobacco use contr	bute to the	e cause of death?
ords	w requires that s been signed t should be deta	ted b	Multiple My	done				1 🗆	Yes 2 □ No	3 🗌 Proba	ably 4 Unknown
Division of Vital Records,	The la	Completed						per	ormed? d	ere autoprior to come alh?	sy findings available apletion of cause of
/ita	ysician: is certifice director.	BeC	25. Was case referred to medical examiner?					Death (Check only	one)		
J o	Phys this al di	٠ <u>۲</u>	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2 E		3 DOA Othe	4 Nursing		idence 6 Othe)
ion	After Fune	atlon	1_Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work M 1 🗀 Y	al ? ′es 2 □ No	28d. Describe	how injury occurre	90	
Divis	ii or Atte after dea i Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, stree	t, factory, office			(Street and Number own, State)	r or Rural	Route Number,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	vsician: To the best of my know iner: On the basis of examination and manner stated.	rledge, death o	occurred at the tim stigation, in my op	e, date and pla inion, death o	ace, and due to the ocurred at the time	cause(s) and mar , date and place, a	ner as stand due to	ated. the cause(s)
	To the within To the	Me	29b. Signature and title of certifier			29c. License	number		29d. Date signed	(Month, L	Day, Year)
			auf au				9083	5	Musuct	11	2010
7			30. Name and address of person who c			int)				2	1133
	Sta		31. Date liled (Month, Day, Year) AUG 1 7 2010	32. Registrar's Signatu	are Am	2		9			
	Registr	ar	AUG 1 7 2010	Aller Co.	No. of the last						

ORIGINAL

DHMH 17 Rev 1/2001

			for State Registrar		State of	Marylar		artme <i>rtifica</i> :			and N	/lental Hy	gien Reg. N	201	0	25591	
	Physicia	ın/	Decedent's Name (F)									2. Date of De	eath D	av	Year	3. Time of Death	
	Medic Examin		John 4a. Facility Name <i>(if not</i>	Michae institution, give		<i>l</i> ernare	5TT1	4b. City	, Town, or	Location	of Death	Augus		c. County of	2010 of Death	7:45 P	1
			Gilchrist 5. Social Security Numb			A		Tow	rson er 1 Year	1 (6) 1 - 4-	. 04 []-	r		Balti			
	Funeral Director		216-24-52	14	X X M 2 □ F	. Age (In yrs. I	Yrs.	Months		Hours	Min.	8. Date of Bit (Month, Da 03/26,	th 1/193	30	g. Birthp Coun Mary	place (State or Foreig 71and	n
	land show dat	ţo	Usual Residence of Dec 10a. State 10	b. County		10c. Cit	y, Town or Lo	ocation							1	0d. Inside City Limits	}
	e Mary r 28a-f notifie	Funeral Director	MD 10e. Street and Number	Baltimo	re	Not	tingh									1 ☐ Yes 2 🛣 N	0
	with th	eral	4012 Silve		na Road	Δnt	m_1		236				0	S.A.	hat Cour	try?	
	death items		11. Marital Status		12. Was Decede Armed Forc	ent Ever in U. es?	S. 13.	Was Dece	dent of Hi	spanic O	rigin? (Spe	ecify Yes or No- Rican, etc.)		14. Race			
039	s filed within 72 hours after death with the Maryland Ital Hygiene. 3d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by	1 Never Married 3 Widowed 4		1 X Yes 2 If Yes, Give Year or Date			1 🗆 Yes	-			,		Specify:	, White, o Whit		
-c -c	"2 hour "natu edical	plet		5. Decedent's Ed only highest gra	lucation		16a. Dece	kind of wo	rk done d	ation	st of work	ing	16b. l	Kind of Bus	siness Inc	dustry	
1212	within 7 giene. Jer than t, the M		Elementary/Seconda	ay (0-12)	College (1-4	or 5+)	life, [o <i>noru</i> s ter S	e retired)			Ů	A	rmed	Forc	reg	
pu	be filed vental Hygerked other	To Be	17. Father's Name (First	, Middle, Last)						18. Motl		e (First, Middle,		Surname)			Т
Maryland 21215-0036	ould brind Mer market matic		Daniel 19a. Informant's Name/	/Relationship (Tv	Vernar	elli	10h Maili	na Addroa	c /Stroot o		ster	al Route Numbe	ou City a	Porr			-
	e 1 and 2 should be file of Health and Mental I If item 27 is marked o ir other traumatic eve		Jane Verna	arelli ,	,		1									am, MD 2123	36
Jore	Page 1 ал nent of H. ant: If iter ury or ott		20a. Method of Disposit	Cremation 3 🔲		tate c	lace of Dispo emetery, crea	osition (Na matory or	me of other place	e)	1	Date	20c. L	_ocation - (City or To	wn, State	
saltimore,	# P E E		4 Donation 5 21. Signature of Funeral			Anat	cony Gif					.6/2010 latomy (_
ñ	permi Depar Impo any ir once.		1 60	DXC	<i>y</i>		7	522 (Conne	lley	Dr.	, Ste.	P, F			MD 21076	
2	Ph_sician/		23a. Part 1. Enter the d shock, or heart fai Immediate Cause (Fina	ilure. List only or il	e cause on each	i line.	h. Do not ent	er the mod	le of dying	g, such as	cardiac o	r respiratory ar	rest,			Approximate Interval Between Onset and Death	
	Medical	Ì	disease or condition resulting in death)	•	a. Due to (or	as a consequ	uence of):	WOTT	1100	140	A 60	NCV			1	CO TO S	_
	Examiner	e	Caquentially list conditi if any, leading to immed	ons,	b. Pue to for	as a consequ					1.17						
-	uted Id ansit	amin	cause. Enter Underlying Cause (Disease or linjur that initiated events	g E	c .	as a consequ	ience oij.										
	eath certificate be executed attending physician and for use as the burial-transit	edical Examiner	resulting in death) Last		Due to (or	as a consequ	ence of):										
200	ficate k g physi as the t			_	d												_
Š X	th certi	ian/	IF FEMALE: 23b. Was decedent preg in the past 12 mont	JII alli		th 2 🗌 Feta	Ideath 3			У				23d. Date Mont			
, o	the dea by the a ached f	Physician/M	1 Yes 2 No 9 Unknown		4 ☐ Pregna 9 ☐ Unknov	nt at time of c	leath 5 L	Other (s _i	pecify)					IVIOIT	.11	Day Year	
ָרָ בְּי	es that signed l		Part II. Other significan	it conditions co	- 1	th but not res		underlying	_	en in Part	I.			1		e cause of death?	
cords,	requir been s	letec	ON NOTICE	231100	ice pe	1110101	2 ar	200				1 🗆 24a. Was		`		ably 4 Unknowr	1
בי בי	The lav ate has page 2	Completed by	L 2002-181 - Daniel									autor perfo 1 \(\sum \) Yes	osv	pri	or to cor ath? Yes	npletion of cause of	
9	sician: certific rector,	Be	25. Was case referred to examiner? 1 Yes 2	.000	lospital:				Othor	r.	ath (Check	only one)				11	
5	ding Physician: The Is h. After this certificate ha funeral director, page	te: 70	27. Manner of Death		28a. Date of	oatient 2 injury Day, Year)	ER/Outpatier 28b. Time of injury		Bc. Injury	_4 ∐ N at		me 5 Resid				HOSOICO	_
2	ttendir death. stor: Af the fur	Certificate:	2 ☐ Accident 3 ☐ Suicide 6 [☐ Pending Investigation ☐ Could not be				М		Yes 2							
	tal or A rs after al Direct ed in by	Se	4 Homicide	determined	28e. Place of building,	etc. (Specify,	me, farm, str	eet, factor	, office			28f. Location (S City or Tow			or Rural	Route Number,	
:	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	ledical	(Check 2 □ M	Medical Examin	cian: To the best er: On the basis Practioner: To	of examination	and/or invest	tigation, in	my opinior	n. death o	ccurred at	the time, date a	nd place	and due to	o the cau	se(s) and manner state	ed.
:	To the comp	≥	only one 304.		. ractioners to		_		License		anu piac	e, and que to the		s) and manr ite signed (
			Kebeca	10 D	unce	. CL		K	145	350	0		Ave	124	15	2010	
	φ		30. Name and address o	Sette	la 55	5 W	-24		5cn+	row)	1 B	rud To	2005	<u>on</u> 1	D	21204	
	State Registra		31. Date (in (Month, Da	010 L	32. Regi	strays Signat	me Market										

			1 State	partment of Health and Mer e <i>rtificate of Death</i>	ntal Hygiena Reg. No	2010 20002
~	Physici	ion	Registrar 1. Decedent's Name (First, Middle, Last)	2.	Date of Death Month Da	3. Time of Death
¥.	/Media	cal	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	tug 17	2010 19,45 M
A.	Examin	ner	Cieno, his tho ne wood	Baltimore	70	N/A
	Funeral Director		5. Social Security Number Cuqqq8562y 6. Sex 1 M 2 F 7. Age (In yrs. last birthda 95 Yrs.	Months Days Hours Min.	Date of Birth (Month, Day, Year, 1/01/191	9. Birthplace (State or Foreign Country) 5 S. Carolina
	/land low at		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	ne Man 8a-f sh xiffied	ctor		imore		1 X Yes 2 No
	th with the 23a or 2 ust be no	Funeral Director	3304 Chesterfield Avenue	10f. Zip Code 21213		tizen of What Country?
136	be filed within 72 hours after death with the Maryland that Hyglene. ed other than "natural", or Items 23a or 23a-f show event, the Medical Examiner must be notified at	by Fune	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Never in U.S. It was Decedent Ever in U.S. Armed Forces? 1 Never in U.S. It was Decedent Ever in U.S. Armed Forces? 1 Never in U.S. Armed Forces?	B. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Ricant I ☐ Yes 2√1 No Specify:	y Yes or No- an, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
5-0036	72 hou 'natura dical E		15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Git	eedent's Usual Occupation we kind of work done during most of working . DO NOT use retired)	16b. k	Kind of Business/Industry
121	within iene. • than *	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	. DO NOT use retired) Omestic	Pri	vate Homes
and	be filed Ital Hyg d other event, 1	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (Fi	irst, Middle, Maider	n Surname)
Z	permit. Pages 1 and 2 should be Department of Health and Ments Important; If item 27 Is marked any injury or other traumatic evonce.	흔		Ella iling Address (Street and Number or Rural R		Brown
Ma	and 2 s alth an 27 Is I er traul		Daisy White (Niece) 330	4 Chesterfield Av		
ore.	Pages 1 and the nent of He int: If item		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Discernation 5 ☐ Removal from State ☐ CSEDIA	position (Name of paratory or other place) H. Brown Crematory 08/18/		ocation - City or Town, State
Saltimor	nit. Pa artmen ortant; injury injury		4 □ Donation 5 □ Other (Specify) F7 H &	Crematory 08/18/		timore, Maryland
ñ	permi Depar Impo any ir		withich N. Williams	oseph H. Brown Jr 140 N. Fulton Ave	Funer Balti	al Home, PA more, MD 21217
		e E H	23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Immediate Cause (Final	nter the mode of dying, such as cardiac or re	espiratory arrest,	Approximate Interval Between Onset and Death
ik _e	Physician /Medical		disease or condition resulting in death) a. Due to (or as a consequence of):			
	Examiner	L	Sequentially list conditions,			
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or injury that initiated events			
Š,	cate be executed physician and the burial-transit	I Exa	resulting in death) Last Due to (or as a consequence of):			
00/00	cate phys the	edical	d			
O. DOX	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	hysician/Me		B⊟Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
ŗ.	s that the ned by a detact	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
cords,	requires	ted b			1 ☐ Yes 2	Probably Handung
	The la	Completed			24a. Was an autopsy performed? 1☐ Yes 2☑ No	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
N I G	ysiciar s certif director	o Be	25. Was case referred to medical examiner? 1 Yes 2 To Hospital: 1 Inpatient 2 EP/Outpati	ent 3 DOA Other: 4 Divising Home		6 ☐Other (Specify)
5	ing Phy After thi uneral o	on: T	27. Manner of Death 1	of 28c. Injury at 28d. Work?	I. Describe how inju	
2	Attend death. cctor: /	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, s	M 1 ☐ Yes 2 ☐ No street, factory, office 28f.	. Location (Street a	nd Number or Rural Route Number,
5	rs after ral Dire	Certi	a Dullaing, etc. (Specify)		City or Town, Stat	
	or the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certifical completely filled in by the funeral director, is	Medical	29a. Certifier (Check only one) 2 Medical Examiner: To the best of my knowledge, de. 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, and investigation, in my opinion, death occurred	d due to the cause(s at the time, date an	s) and manner as stated. Id place, and due to the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier	29c. License number		ate signed (Month, Day, Year)
Ì	1 2 4		162	D0070076	08	3 16 10
	V		30. Name and address of person who completed cause of death (Item 23a) (Type 88 3 walkman wood R 5	D0070076 10 204, Parkvill	a mb	21234
	Sta Registr	_	31. Date filed (Month, Day, Year) 32. Registrar's Schature	K)		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 30/0 Physician/ Francis T. Whittle 3: Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Balt: Square Rosedale Hospita more Franklin 8. Date of Birth (Month, Day, Y Birthplace (State or Foreign Country) Security Numbe If Under 1 Year If Under 24 Hrs. **Funeral** Hours 1 **X** M 2 □ F Months 218-28-4469 78 Director Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location death with the Maryland **Funeral Director** Middle River Baltimore MD 1 Yes 2 X No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21220 USA 20 Cypress Lane 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status à 1 Never Married 2 Married 2 🙀 No within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 √ No Specify: Specify: White Completed 3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Self-employed Carpenter 12th Be 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) of Health and Mental H If item 27 is marked ot r other traumatic ever ٩ 2 should be Elizabeth Kunkle Roland Whittle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trau 20 Cypress Lane Balto. MD 21220 Gary Whittle /son 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place)
Oak Lawn Cemetery 8/17/10 1 😾 Burjal 2 🗆 Cremation 3 🗆 Removal from State Baltimore MD tion 5 Cher (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD etello Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician · ventricular disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Segment Secura hally list or utilities, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed this certificate Yes 2 N within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA Certificate: To 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours ε To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, could consume at the time, can and due to the cause(s) and manner as stated. 29a Certifier (Check

State Registrar Signature and title of certifier

me and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

Peckins

Certifying Nurse Practioner: To the best of my knowledge, odeth contined at the time, date and plans, and due to the se

9000 Franklin

29d. Date signed (Month, Day, Year)

Squale Drive Baltimore, MD 21237

13,2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar 25594 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Thomas Kevin Watts AUGUST 2010 Medical 4a. Facility Name (If not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE WASHINGTON MEDICAL DURNIE GHEN INNE HRUNDEL If Under 1 Year 8. Date of Birth (Month, Day, Year) Social Security Number . Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign Days 1**X**XM 2 □ F Hours Min. Country) 213-70-2791 53 Yrs. Director MD 08-05-1957 Usual Residence of Decedent 28a-f shov 10b. County 10a, State 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director notified Baltimore MD Baltimore 1 Yes XXNo 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be 3010 Virginia Ave. 21227 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces?

1XX Yes 2 [
If Yes, Give ō þ 1 Never Married 2 Married 2 🗌 No Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: White 27 is marked other than "natural", traumatic event, the Medical Exa Completed 3 Widowed 4 Divorced If Yes, Give Year or Dates. 1976-1977 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Construction Electrician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental James L. Watts, Sr. Marlene Cavey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra once. Jay Kenton Watts 7607 New York Ave., Hudson, FL 34667 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) MD Veteran Cemetery 108/17/2010 Crownsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wester Bailey Funeral Home and Cremation Service, PA M01452 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line. Road, Halthorpe, MD 21227 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as Examiner COLON PERFORATED Sequentially list conditions, it is year and good for models cause. Enter Underlying Examiner that the death certificate be executed Cause (Disease or linjury that initiated events COAGUCOPAT attending physician and for use as the bunal-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: fyes, outcome of pregnancy ☐ Live Birth 2☐ Fetal death 3☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death signed by the a 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has autopsy performed Hospital or Attending Physician: The Yes 2 No 1 Yes Division of Vital ours after death.

Ineral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital Other: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manne of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending injury 1 Natural work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined To the Hospital within 24 hours a To the Funeral Completed filled is 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 Hospital Dr. Tsion Berhane, Glen Burnie.

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

AUG 1 7 2010

WATTS

32. Registrar's Sign

MD 21061

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygienes 25595 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 08 Physician/ Day 5 1:15 amm Whittington R. Jerome Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Union Memorial Hospital Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 1 **X** M 2 □ F Months Days Min. Hours Country) **Director** 71 28 3-32-762 08 32 MD ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 X Yes 2 No MD NA Baltimore 10e. Street and Number 10g. Citizen of What Country? Funeral 2937 Gwynns Falls Parkway U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Black, White, etc. 9 þ 1 Never Married 2 Married Maryland 21215-0036 1 Tes 2 No Specify: "natural" 3 Widowed 4 Divorced Completed Black Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me lementary/Seconday (0-12) College (1-4 or 5+) 11th grade Crain Operator Beth Steel Corp. na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Jimmy Mobrey Elsie Whittington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21216 Baltimore, Mildred Whittington-Wife <u> 2937 Gwynns Falls Parkway, Baltimore, </u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet 8/20/2010 Owings Mills, 21 Signature of Funeral Service Licer March Address of Eacility t March Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ End Slage 18 chemic cardiom disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 2004 (byay) Coronary a Esquentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a conseque e of): the Hospital or Attending Physician: The law requires that the death certificate be executed ohysician and the burial-transit Doge Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending photoe IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death Day Year 2 No been signed by the should be detached 9 Unknown q Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed

1 Yes 2 No certificate has 1 Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2/ No Hospital Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 6 Other (Specify) eral Director: After thi filled in by the funeral 27. Mannar of Death Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending iniurv Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) within 24 hours a To the Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 08/15/10 $M \cdot D$ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimor David , M.D Memonal

State

Registrar

AUG 172010

32. Registra

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TIEM#25perME, G906, 8/27/2010, WS
State of Maryland / Department of Health and Mental Hygiene [] | [] 25596 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month lex 15:27M 0 aurice ugust Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Bayview Hopkins Med (ente Saltimore N/A f Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign M 2 🗆 Months Hours Min. (Month, Day, Year) Director New York lovember 02,1956 Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 🗆 Yes 2 🛣 No Maryland Anne Arundel Crofton 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 906 Eastham Court Apt T-2 21114 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Specify: Black 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Andrews Air Force Elementary/Seconday (0-12) College (1-4 or 5+) 12 <u>Senior Building Monitor</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Maurice Richard Waller, Sr. Revella Harrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maritha Gay, Sister 7179 Moorland Drve, Clarksville, Maryland 21029 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 D Burial 2 🙀 Cremation 3 D Removal from State 4 Donation 5 Other (Specify) Metro Crematory, Inc. 8/16/2010 Baltimore, Maryland Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ morrhage disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** ance Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed CERTIFICATION APPROVED BY MEDICA that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Month Year 2 🗌 No 9 Unknown sate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed death? 2 1 No 1 🗌 Yes Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: ၉ 1 Inpatient After this 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending Accident
Suicide neral Director: A Investigation 1 Yes 2 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) Physician Resident RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stanley Liu Easte ^{Year)} 2010 31. Date filed (Month, 2. Registrar's Sign State Registrar

DHMH 17 Rev 7/2009

			State of Maryland / Dep	artment of Health and I	Mental Hy	giene	
				rtificate of Death		Reg. No. 2 1 1	25507
	Physicia	ın/	1. Decedent's Name <i>(First, Middle, Last)</i> Nancyann Waldron		Date of Dea Month	ath Pay and Year	3. Time of Death
بهدسد	Medic	al		1	August	10 ^{pay} 2010 ^{Year}	9:08 P M
	Examir	er	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death Bethesda	1	4c. County of Death	
· where	Ermanal		9313 Linden Ave. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birt	Montgome	pplace (State or Foreign
	Funeral Director		057-50-0222 1 □ M 2 🖫 F 55 Yrs.	Months Days Hours Min.	(Month, Day	r 24,1954 New	ntry) York
	W		Usual Residence of Decedent		юсрешье	2 2 1, 233 1, 10 11	
	yland if sho ed at	햕	10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits
	e Mar 28a- 10tifie	Director	Maryland Montgomery Bethesda				1 Yes 2 X No
	ith the	ra [10e. Street and Number 9313 Linden Ave.	10f. Zip Code 20814		10g. Citizen of What Cou United Stat	•
	within 72 hours after death with the Maryland giene. et than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Funeral		Was Decedent of Hispanic Origin? (Sp		14. Race - Ameri	
ယ	er de or ite nine		Armed Forces? 1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2 🛣 No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White	
g S	ırsaft ırral", IExal	ed	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2 X No Specify:		Specify: Whi	te
2	2 hou "natu adica	Completed by	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of won	kina	16b. Kind of Business II	ndustry
12	than than	ĕ	Elementary/Seconday (0-12) College (1-4 or 5+) life. D	OO NOT use retired)	9	Self Employ	rod.
D D	ed wil Hygie other	Be	17. Father's Name (First, Middle, Last)	culturist	as /Eirot Middle	Maiden Surname)	
aŭ	be fill ental ked c	ျှ	Maurice Waldron	Elizah		Dunay	
ary	nould ind M s mar umat			ng Address (Street and Number or Rui	ral Route Number	r, City or Town, State, Zip	Code)
Σ	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If fire 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		Randolph Desonia/Husband 9313	Linden Ave., Bet	hesda,	MD 20814	,
ore	of He of He If iter		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, creation 3 ☐ Removal from State	osition (Name of matory or other place)	t ^{Date} 13,	20c. Location - City or 7	own, State
<u>Ē</u>	Pagitment tant:		4 Donation 5 Other (Specify)	Crematorium 2	2010	Bethesda, N	1D
Baltimore, Maryland 21215-0036	permit. Page 1 Department of Important: If i any injury or o once.		21. Signature of Funeral Service Licensee	2. Name and Address of Facility bert A. Pumphrey Funer 57 Wisconsin Ave., Bet	al Home/Be	ethesda-Chevy C	hase Inc.
_	EB = 10 01		23a. Part 1. Enter the disease, or complications that caused the death. Do not ent				
			shock, or heart failure. List only one cause on each line.	er the mode or dying, such as cardiac	or respiratory air	est,	Approximate Interval Between Onset and Death
- +	hysician/ Medical		disease or condition resulting in death) Ovarian Cancer Due to (or as a consequence of):				Onset and Death
-	Examiner						
	- +	Examiner	Sequentially list conditions, if any, leading to the conditions, b. Due to (or as a solice quence of, cause. Enter Underlying				
-	and trans	xan	Cause (Disease or linjury that initiated events c. Due to (or as a consequence of):				
_	death certificate be executed the attending physician and ed for use as the burial-transit	dical	resulting in death) Last Bue to (or as a consequence of).				
760	phys the	ledio	d				
89	cerrii anding use a	N/N	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	75		23d. Date of deliv	/ery
Вох	e atte	sicia	1 Ves 2 X No 4 Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		Month	Day Year
		Physician/Me	9 Li Unknown				
P.O	ine law requires mat me de ate has been signed by the page 2 should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.		obacco use contribute to	
g	equire	etec			1 .	Yes 2 X No 3 □ Pro	111
၀ ဂ	has has	Completed			24a. Was a	an 24b. Were auto psy prior to co rmed? death?	opsy findings available ompletion of cause of
ř	sician, the is certificate ha rector, page		25. Was case referred to medical		1 🗆 Yes		2 □ No
/Ita	sicial s certi lirecto	To Be	examiner? 1 Yes 2 X No Hospital: 1 Inpatient 2 ER/Outpatien	26. Place of Death (Chec			.,
to	g rny er this eral c		27. Manner of Death 28a. Date of injury 28b. Time of	28c, Injury at		lence 6 Other (Speciform Office	y)
Division of Vital Records,	ath. r: Aft	ficat	1 X Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident Investigation	work? M 1 ☐ Yes 2 ☐ No			
NISI VISI	fer de irecto by ti	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (S City or Town	itreet and Number or Rura n. State)	il Route Number,
בֿ בֿ	ours a seral D		Constitution of the second of	1			
3	24 hc Fun	Medical	29a. Certifier (Check 2 ☐ Medical Examiner: On the best of my knowledge, death (Check only one) 3 ☐ Certifying Nurse Practioner: To the best of my knowledge, death (Check only one)	tigation, in my opinion, death occurred a	at the time, date ar	nd place, and due to the ca	ause(s) and manner stated.
- T	our nospinal or Australian graysican, within 24 hours after death. To the Funeral Director After this certific completed filled in by the funeral director,	2	29b. Signature and title of certifie	29c. License number		29d. Date signed (Month,	Day, Year)
			1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	D29675		August 12,	2010
		i	30. Name and address of person who completed cause of death (Item 23a) (Type, F	· ·		0017	
			Ralph Boccia M.D., 6420 Rockledge Dr		, MD 2	0817	
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature	/			

DHMH 17 Rev 7/2009

			for State Registrar	State of IVI	•	Certificate of			leg. No. 0 0	25598
	Physici	on.	1. Decedent's Name (First, Middle, La	st)				2. Date of Dea Month	th Day Year	3. Time of Death
-	/Medic		George C. White,					August	13, 2010	8:05 P M
* SP	Examir	ner	4a. Facility Name (If not institution, given the second of	· · · · · · · · ·			or Location of Death		4c. County of Dea	
_	Funeral		Wilson Health Car 5. Social Security Number 6.8		ge (In yrs. last birth	Gaither	If Under 24 Hrs.	8. Date of Birth (Month, Day	Montgom 9. Bi	ery rthplace (State or Foreign ountry)
	Director		134-07-9382 Usual Residence of Decedent	1 🕅 M 2□ F	95 Y	rs. Months Days	Hours Min.	ecember	11, 1914 Penr	
	/land		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	a-fsh	cto	Maryland Montgo	merv		Gaithe	ersburg			1X Yes 2 No
	or 28	Director	10e. Street and Number		,	10f. Zip Code			10g. Citizen of What C	ountry?
	ath w		301 Russell Avenu	T			0877		United St	
336	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show dical Evan front that be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 【X Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates:		13. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 🛣 No		cify Ye <i>s</i> or No- Rican, etc.)	14. Race - Am Black, Whi	te, etc.
2-0	hin 72 hou e. an "natur a M. dheal E	ted	15. Decedent's E. (Specify only highest gr	ducation	16a. I	Decedent's Usual Occu 'Give kind of work done	pation	10	16b. Kind of Business	s/Industry
21215-0036	F 3. F 3.	Completed	Elementary/Secondary (0-12)	College (1-4or t	5+)	life. DO NOT use retire	nd)	9		
121			17. Father's Name (First, Middle, Last	4	Aeı	conautical	Engineer 18. Mother's Name	(First Middle	NASA Maidan Surnama)	
Maryland	be d d	Be	George C. White,				Lydia Ha		ivialderi Surrame)	
Z	d 2 should be th and Menta 7 is marked traumatic ev	မ	19a. Informant's Name/Relationship		19b.	Mailing Address (Stree			r. Citv or Town. State.	Zip Code)
Ma	1 and 2 s Health ar em 27 is other trau		Carol White / Dau	•	1				-	York 10024
re,	s 1 and of Healt item 2		20a. Method of Disposition			Disposition (Name of crematory or other pla		ate	20c. Location - City o	
E	Page nent o ant: if ary or		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of Cont			Memorial Parl	i	17, 2010	Rockville	, Maryland
Baltimore,	permit. Pages 1 and Department of Heall Important: If item 2 any Injury or other once.		21. Signature of Funeral Service Dice	nse	M01530	Robert A. Pu 300 West Mon	ess of Facility mphrey Funera	al Home,	Rockville, I	nc.
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused	d the death. Do no	ot enter the mode of dv	ing, such as cardiac o	r respiratory ar	rest,	Approximate Interval Between
· Max	Physician		Immediate Cause (Final disease or condition	Con	gestin	eherri arten	traile	ru		Che week
	/Medical		resulting in death)	a Due to (or	a consequence of):	0			
	Examiner	_	Secuentially list conditions	b	rary	arten	Laurea	re		
	ted	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence of):				
	execu n and al-trar	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consequence of	j):				
68760,	tificate be executed g physician and as the burial-transit	ledical E		d						
			IF FEMALE:							
O. Box	that the death cer ned by the attendin detached for use	Physician/	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death	3 ☐ Ectopic pregnan 5 ☐ Other (specify) _	су		23d. Date of d Month	elivery Day Year
ds, P.	The law requires that the ate has been signed by thoage 2 should be detache	þ	Part II. Other significant conditions of the pathypa	contributing to death b		the underlying cause gi	ven in Part I.	23e. Did to		to the cause of death?
of Vital Records,	w requires t s been signe should be	Completed	4 nemia of	chunic	disca	de bl		24a. Was a	an 24b. Were	autopsy findings available
æ	The lav	E E	Dementi					autop perfor 1 □ Yes	med? death?	completion of cause of
ital	75	Be C	25. Was case referred to medical examiner?				26. Place of Death			
<u>></u>	Physician: this certific ral director, p	2	1 ☐ Yes 2 ☐ Wo		ent 2 ☐ ER/Out	oatient 3 DOA Ot	her: 4 🖪 Nursing Hor	ne 5 🗆 Resid	lence 6 ☐ Other (S _k	ecify)
n		ü.	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury 28b. Ti ay, Year) Inj	ury Wo	rk?	8d. Describe h	ow injury occurred	
Sic	Attending r death. sctor: After by the fune	icat	2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b	e 29a Place of Ini	iuns - At homo farr	M	Yes 2□No	19f Location /6	Street and Number or	Pural Pouto Number
Division	al or Attendest s after death il Director; ed in by the	Certification:	4 Homicide determined	building, et	c. (Specify)	n, street, lactory, onice	-	City or Tow	n, State)	ruiai noute Numbei,
	To the Hospital or Atten within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical (29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exa	hysician: To the best miner: On the basis of and manner st	of examination and	death occurred at the look or investigation, in my	time, date and place, a opinion, death occurr	and due to the ed at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
	To the within 2 To the completed	Me	29b. Signature and title of certifier				se number		29d. Date signed (Mo	
			1. Roberto	ischke	dus	024	4115		4ugust	14,2010
				completed cause of described	death (yem 23a) (1	Type, Print 201 A	CUSSELL THERSE	4VE,	VUE 202	777
	Sta Registr		31. Date filed (Month, Day, Year) AUG 17 201	32. Registi	rar's Signature	borker				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19a, Per ANA BD 916 6/29/2011 JH. State of Maryland Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Tay 2010 9:40 Annabel Wolfe August Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Rockville Casey House If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Oct 17, 1916 Social Security Number 7. Age (In yrs, last birthday Funeral 9. Birthplace (State or Foreign 1 □ M 2 🛛 F New Jersey Director 578-61-3242 93 Usual Residence of Decedent show 2 should be filed within 72 hours after death with the Maryland than DMetall Hyglene. 27 is marked other than "natural", or items 23a or 28a-f shootraumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Silver Spring 1 🗌 Yes 2 🏻 No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 20910 USA 10000 Brunswick Avenue #603 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 🔀 No Specify: If Yes Give 3 XWidowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) own home homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jacob Kagan Mollie Kliegman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10000 Brunswick Ave #603; Silver Spring, MD 20910 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Sharon Wolfe wife Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1 ☐ State 21. Signature of Francisco Scicenwade, Director 22. Name and Address of FacilityState Anatomy Board 655 W. Baltimore Street; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition CONGESTIVE Medical resulting in death) Due to (or sequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of, and -transit To the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year 1 Yes 2 9 Unknown been signed by the should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Denestia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4x Unknown Completed 24b. Were autopsy findings available end Trouticience 24a. Was an page 2 s prior to completion of cause of death?

1 Yes 2 No autopsy performed? Yes 2 XN certificate Division of Vital funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 🗌 Yes 2 😾 No ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 □ Nursing Home 5 □ Residence 6X Other (Specify) hospice 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 1 🔀 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b, Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R120698 8/10/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Nicole Christenson 6001 Muncaster Mill Road; Rockville, Maryland 20855 32. Registrar's Signature State parker Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 25600 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year 12:42AM Frederick W. Wengert 2010 2020 Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE MEDICAL ANNE ASHINGTON BURNIE GLEN HRUNDEL STER If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Social Security Number e (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 03/29/1920 1**XX**M 2 □ F Months Days Hours Min. Yrs Director 212-03-8870 90 Usual Residence of Decedent 28a-f shov 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked outher than "natural", or items 23a or 28a-f sho any injury or or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Co. Glen Burnie 1 Yes 2X No Maryland 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21061 United States 612 Aquahart Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Wengert, Frederick Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 X Widowed 4 Divorced Specify: White Completed WWIT 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Shop Foreman Middleton Meads Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Frederick Η. Wengert Marv 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Frederick Wolf / Son 1410 Peregrine Path Arnold, MD 21012 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park | Aug. 16,2010 Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation any in once. M01121 Services PA; 1 2nd Ave SW, Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Due to (or a a consequence Examiner Sequentially list conditions. Examine cause. Enter Underlying Cause (Disease or iinjury burial-transi that initiated events resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 the use as yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 months?

1 Yes 2 No for Month 5 Other (specify) Dav Year Pregnant : Pregnant at time of death been signed by the s ☐ Unknown art II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has autopsy page 2 2 No 1 Yes Yes 2 . Was case referre examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 2 ပ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 1 Natural Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniurv 5 Pending work? 1 ☐ Yes 2 ☐ No death. Accident Investigation 24 hours after deat Funeral Director: pleted filled in by the 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one

State Registrar

DHMH 17 Rev 7/2009

within 7

29b. Signatur

and title of certifier

ss of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 25601 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10, 20'10 Linda Karen Wells August 7:10 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1909 Griffis Ave. Baltimore City 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) Nov. 4,1960 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 M 2 F 218-86-4916 49 Yrs Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner mast be mutited at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Director MD. Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1909 Griffis Ave. 21230 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian. 11. Marital Status 1 □Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🖁 No Specify: þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Disabled Disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kenneth L. Parks Mary Perry ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeffrey A. Wells/ Husband 1909 Griffis Ave.Baltimore, Maryland 21230 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Cedar Hill Cemetery Aug. 16, 2010 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Qther (Specify) 21. Signatur of Funeral AMBRUSE FUNERALLY HOME OF LANSDOWNE 2719 Hammonds Ferry RD., Lansdowne, Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARIOVASC Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Division of Vital Records, P.O. Box 68760, Due to (of as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a □Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been sirector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ◯No 24a. Was an autopsy beadder 1 ☐Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 XYes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Naturai 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 🗷 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 350 31. Date filed (Month, Day, Year) State Registrar

		1 - For State Registrar	State of	Maryland /		irtment of F tificate of L		d Mental H	ygiene Reg. N	010	256	:02
		Name (First, Middle, Last Name (First, Middle, Last))				Journ	2. Date of D	eath		3. Time o	of Death
Physici /Medic		Murtle			W	rite_		Month	Day	2010	16 2	0 PM
Examin		4a. Facility Name (If not institution, give		er)		4b. City, Town, or		eath	4c. C	County of Death		
[The Johns Hopkins Ho 5. Social Security Number 6. Se		Age (In yrs. last b	oirthdav)	Baltimore If Under 1 Year	If Under 24 I	Hrs. 8. Date of B	irth	9. Birth	place (State	or Foreian
Funeral Director		218-22-1827	□ M 2 🔀 F	83	Yrs.	Months Days	Hours M	May 1	^{0ay, Year)} 6 , 1927	7 Mary		
and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	eation					10d. Inside C	City Limits
Maryland	tor	MD Carroll		Elders								2 <u>X</u> No
th the or 28a	Director	10e. Street and Number		LITUELS	Durg	10f. Zip-Code			10g. Citize	en of What Cou	ntry?	
ath wil		5645 Wallace Cou				21784				State		
Nore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	y Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decede Armed Force 1X Yes 2 If Yes, Give	es?	1	Vas Decedent of H Yes, specify Cuba ☐ Yes 21X No	lispanic Origin? an, Mexican, Pu Specify:	' (Specify Yes or N Jerto Rican, etc.)		 Race - Ameri Black, White, Specify: Whit 	etc.	
21215-0036 d within 72 hours aff giene. er than "natural", or the Medical Examir	ed by	3 🔀 Widowed 4 □ Divorced 15. Decedent's Ed	Year or Date			lent's Usual Occup	pation			d of Business/li		
215-	Completed	(Specify only highest grad	le completed) College (1-4		(Give	kind of work done of NOT use retired	during most of	working	100. 1311	d of Buomesoyn	iddoti y	
212 21 with ad with general ser than the M	Com	8th	N/A	, l_	amtr	ess	r			ent/Clos	hing	
Maryland 212.12.12 of 2 should be filed within the and Mental Hygene. The marked other than traumatic event, the Me	Be	17. Father's Name (First, Middle, Last)					_	Name (First, Midd		Surname)		
aryla should ind Men ind Men in marke umatic (၉	Mordicai Buckingl 19a. Informant's Name/Relationship (Ty		19	h. Mailir	g Address (Street		. Kreame:		Town, State, Zi.	Code)	
and 2 s and 2 s ealth an n 27 is i	- 39	William E. White,		Ī		Wallace					,	
altimore, IN rmit. Pages 1 and 3 partment of Health portant: If item 27 y injury or other tr.		20a. Method of Disposition		20b. Place	of Dispo	sition (Name of patory or other place	i	Date	20c. Loc	ation - City or T	own, State	
Fages ment of ant: If its ury or o		1 XBurial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify)		uc	wrid	ge Mem. I	Park Au					d
Baltimo permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service License	371	1		Name and Addre						007
202 80		23a. Part 1. Enter the disease, or comp	lications that cau	sed the death. Do		28 Sulphu				, Maryıa	Approxima	ite
Physician		shock, or heart failure. List only or Immediate Cause (Final	ne cause on each	n line.	Villa.	101	****				Interval Be Onset and	
/Medical		disease or condition resulting in death)	a. Due to (or	as a consequenc	⊬ <i>€</i> ಬ e of):	CH TAIL	orti.					
Examiner	_	Sequentially list conditions,	b. Perice	- lish	4000	per-le						
sit ed	Examiner	Sequentially list conditions, if my leading to kin in-dist cause. Enter Underlying Cause (Disease or injury	A 1	as a consecuenc						-		
xecut		that initiated events resulting in death) Last	c. Acct Due to (or	as a consequence	e of):							
box 68760, cdeath certificate be executed attending physician and address as the burial-transit	edical		d									
68 ertificat		IF FEMALE:										
BOX 6 Jeath certifi attending I d for use as	sician/M	in the past 12 months?	1 Live birt	me of pregnancy h 2 □ Fetal dea It at time of death		Ectopic pregnanc	у		23	Bd. Date of delive Month	ery Day	Year
rat the de detached	Physi	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	9 Unknow									
	by	Part II. Other significant conditions co	ntributing to deal	th but not resulting	g in the u	nderlying cause gi	iven in Part I.			e contribute to		death? Unknown
Hecords, le law requires thas been signer ge 2 should be 1	Completed							24a. Wa:		24b. Were aut		
- o o l	ошо							auto per 1 □ Yes	opsy formed? 2 No	death?	ompletion of	cause or
T VI(al KeC ysician: The law s certificate has b director, page 2 s	BeC	25. Was case referred to medical examiner?						Death (Check only	/ \			
OT V	ျှ	1X Yes 2 □ No	Hospital: Inp			3 DOA Othe	4 🗆 Nursing	g Home 5 Res		Other (Speci	fy)	
On ding P	tion	27. Manner of Death 1 Natural 2 Accident Accident Natural Investigation	28a. Date of I (Month,	Day Year)	. Time of Injury	28c. Injun Work	yat k? Yes 2 ⊡ No	28d. Describe	now injury	occurred		
DIVISION OF VITAL al or Attending Physician: T s after death. Il Director: After this certificat ed in by the funeral director, p	ifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of	injury - At home,	farm, stre					Number or Ru	al Route Nur	nber,
tal or safte	Certification:	*	building.	, etc. (Specify)				City of 10	wn, State)			
To the Hospital or / within 24 hours after To the Funeral Dire completely filled in E	Medical	29a. Certifier (check only one) Certifying Phy 2 Medical Exam		s of examination a								(s)
To the comp	Me	29b. Signature and title of certifier	PA			29c. License			29d. Date	signed (Month,	Day, Year)	
		PULL	10	•		RES	- 000		Augus	st 06	2010	
5		30. Name and address of person who o	ompleted cause	of death (Item 23a	a) (Type,	Print)	ബ	0 North W	olfa St	Baltimo	re. MD	21287
Sta	te	31. Date filed (Month, Day, Year)	32. Regi	trar's Signature				O ROILLS W	JIIE OL	, Daniiio	, 11110,	2.201
Registra		AUC 179	040			2.41				٠		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#1perPHYS. G906.8/17/2010 WS
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Leonard (Young Sr. Physician/ onar 80 2010 7:00p. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 00 C Belle Baltimore Baltimore 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Months Davs Hours (Month, Day, Year) Director 82 06 220-20-4111 MD f show be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director or 28a-f MD 1x Yes 2 □ No NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 5500 C Bell U.S.A 21207 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 X Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: "natural", Black 3 ₩ Widowed 4 □ Divorced Specify: Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 2th Grade 4vrs+ Mail Carrier Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Florence Blackston Hamilton Wade Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Young-Son <u>5500 C Belle Ave, Baltimore, Md 21207</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ABurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet 8/17/2010 Owings Mills, Md 21. Signature of Funeral Service Licensed 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, 21215 Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Failure to thrive disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner acheria Sequentially list conditions, if any, leading to immediate cause. Enter onderlying Cause (Disease or iinjury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Other (specify) Month Day Year Yes 4 ☐ Pregnant : 9 ☐ Unknown been signed by the should be detached 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has I funeral director, page 2 s autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \(\triangle \text{ Nursing Home } 5 \(\text{XF} \) Residence 6 \(\triangle \text{ Other (Specify)} \) 1 ☐ Yes 2 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural
Accident
Suicide injury 5 Pending Investigation 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b, Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO D35844 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO Suite 108 21133 5400 old Court Road Randallstown 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Martin Julious York, Jr. State of Maryland / Department of Health and Mental Hygiene 2010 25604 1- For State Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death Medical Examine August 7, 2010 0114 hrs MARTIN JULIUS YORK, JR. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University Hospital Baltimore 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Director Months Days 1X M Country) MD 2 F 218–62–7699 55 1954 AUG. 20, Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits narked other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at once. 28a-f shor 1 X Yes 2 No death with the Maryland BALTIMORE Director CATONSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1022 LAKEMONT RD uneral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black 1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1X Yes jes I and 2 should be filed within 72 hours after of Health and Mental Hygiene. 3 Widowed 4 X Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: BLACK 2 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Compl 12TH CARPENTER SELF EMPOLYED 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ MARTIN J. YORK, SR.

19a. Informant's Name/Relationship (Type, Print) OZIE B. YORK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 DONNA L. GILLIAM/SISTER 1022 LAKEMONT AVE., CATONSVILLE, MD20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Donation 5 Other Specify. CROWNSVILLE 08/12/2010 CROWNSVILLE, MD 21. Signature of Funeral Septice License 22. Name and Address of Facility WESLEY CHAVIS, JR., FNRL. HM. 2007-09 EASTERN AVE., BALTIMORE, MD Part I. Enter the disea ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** e. or complication Approximate Interval failure. List only on /Medical en Onset and a. Gunshot Wound of the Head Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and transi* The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED e attending physician for use as the burial Box 68760 JF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Day past 12 months? 2 Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.0. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 ✓ No 3 Probably 4 Unknown Records, Completed After this certificate has been uneral director, page 2 should 24a, Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed' death? 1 ✓ Yes 2 No 1 🗸 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Hospital: 1 ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other Nursing Home 5 Residence 6 Other 1 V Yes 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) Aug 7, 2010 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? Certification: 1 Natural 0032 hrs Subject shot Director: 5 Pending 1 Yes 2 ✔ No Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Unit Block N. Shipley Street, Baltimore, MD determined within 24 hours To the Funeral (Specify) Local Street 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 7, 2010 Man 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Register's Signature 31. Date filed (Month State

DHMH 17 Rev 1/2001 OCMF 2006

Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [25605 = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month William Zissimos 2010 2:30PM M August Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 808 Joshua Tree Court Baltimore Owings Mills Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, 311 🗶 M 2 🗆 F Hours Min Months Director 213-38-9371 69 MD Usual Residence of Decedent or 28a-f show 10a. State death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c, City, Town or Location 10d. Inside City Limits Director MD 1 🗌 Yes 2 🔀 No Baltimore Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 808 Joshua Tree Court 21117 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🐰 No Black, White, etc. 1 Never Married 2 Married Completed by within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give "natural", 3 X Widowed 4 ☐ Divorced Specify. Year or Dates White other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) pernit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) 11College (1-4 or 5+) Dump Truck Driver Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ William Atha Zissimos Loma Day 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter Melanie Deak 3037 4th Ave., Parkville, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 8/10/10 Carroll Cremation Hampstead, MD Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Ce Eline Funeral Home Reisterstown, MD 21136 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death ardiac Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner dist = si ara Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death cer ficate be executed or use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) ttending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Month Year Yes **neral Director:** After this certificate has been signed by the filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 1 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: မ 1 Tyes 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Mann of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Vatural 5 Pending Accident Suicide 1 Yes 2 No Investigation within 24 hours after deati To the Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 💆 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of cert 29c. License numbe 29d. Date signed (Month, Day, Year) 1057169 Vario 10, 2010 address of person who completed eause of death (Item 23a) (Type, Print) 30. Name and 1 MONIUM.

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

0-05706				e or Print in B									
inthony Lee Ai		1- For State Registrar		ate of Maryland			of Health a of Death	nd Men		Re	g. No.	010	25606
Physic Medical Exam		1. Decedent's Name	e (First, Middle Ony I.ee						N	Date of Deatl Month Uly 30, 20	Day	Year	3. Time of Death 0045 hrs
		4a. Facility Name (i Prince Geor		, give street and number)		4b. City, Town, Cheverly	or Location			4c. Cou	nty of Death	
Funeral		Social Security N		<u> </u>	ge (In yrs, las	t birthday)	If Under 1 Y	ear If Unde			h(MM/DD/Y	YYY) 9. Birl	thplace (State or
Director		298-50-0		1 M 2 F	57	Y	rs. Months Da	ays Hours	s Min. (09/02/	1952	Foreig	untry) OH
Maryland 28a-f show any d at once.	_	10a. State	10b. County Montgo	omery	10c. City, T	own or Loc ver Si					· · · · · ·		10d. Inside City Limits 1 XYes 2 No
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygient Annual Hygient Signature of Incents I filed and State of sher than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Nur 12902 B		n Drive	J		10f. Zip Code 2090			10	g. Citizen of USA	f What Cour	ntry?
death with or items 23 must be no	Funeral	11. Marital Status 1 Never Marrie	ed 2 Mar	ried 12. Was Deceden Armed Forces 1 Yes 2			Vas Decedent of H Yes, specify Cub				٧	Vhite, etc.	can Indian, Black,
rs after ural",	ρ	3 Widowed		rced If Yes, Give Year or Dates: fy only highest grade cor	noleted) I 1	1 Decede	Yes 2 X N			done		BLac	
72 hounnate	eted	Elementary/Seco		College (1-4 or		during	most of working li	fe. DO NOT		done			naustry
OO3(within giene. her that	Completed	17 Father's Name (Eiret Middle I	2		Trair	ning Man		's Name (Firs	t Middle M		vate	
1215. be filed ental Hy orked or	Be	17. Father's Name (John A							tha Ale				
MD 2's should the and Mo 12's is me 12's is me unnatic en	To	19a. Informant's Na Rosealary				12902	ng Address (Street)	rn Dri					
More, Pages I and bent of Heal ant: If iten		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) Westwood Cemetery 20c. Location - City or Tow 08/09/2010 Oberlin, OH											
Balti permit. Departu Import.		21. Signature of Fur	neral Service	icensee			Name and Addre			רי אדא זא	achin	oton	DC 20011
Physician Medical				omplications that caused n each line. a Multiple Injuries									Approximate Interval Between Onset and Death
kaminer		Immediata Cause (F or condition resultin		Due to (or as a cons									
	iner	Sequentially list con if any, leading to im- cause. Enter Under	mediate	Due to (or as a cons	equence of):								
xecuted n and - transit	Examiner	(Disease or injury the events resulting in o		Due to (or as a const	equence of):								
ਹ ਕਰ	dical	UNPENDED		AMENDED			····						
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be 24 hourst after death. Funeral Director: After this certificate has been signed by the attending physicialy filled in by the funeral director, page 2 should be detached for use as the buri	sician/Med	IF FEMALE: 23b. Was decedent p past 12 months?		23c. If yes, outcor 1 Live birth Pregnant at	ne of pregnar	2 🔲 F	etal death 3	Ectopic	pregnancy		23d. Date Month	e of delivery	ay Year
BOX he death y the atte	Physi	1 Yes 2 N	o 9 Unkn	own 9 Unknown		٠ د				22- Didi-			the cause of death?
ires that the signed by	ò			ns contributing to death	1 but not rest	Juling in the	underlying cause	giveri iri Fai					ably 4 Unknown
Division of Vital Records, sale or Attending Physician: The law requiral price death of the law requiral birectors. After this certificate has been sited in by the funeral director, page 2 should the formeral director, page 2 should the formeral director.	Completed	41-10-1-1				_				24a. Was ar autopsy perform Yes 2	red?		topsy findings available ompletion of cause of
ian: The certificate ector, page	Be Co	25. Was case referre	ed to medical				26 Plac		(Check only o			1 💆 10.	3 2 10
F Vit Physica r this o	To E	1 ✓ Yes 2	No	Hospital: 1 Inpatie		VOutpatien			Nursing Hor		esidence (:
tion of trending P death. stor: After y the funera	Certification:	27. Manner of Death1 Natural2 Accident	5 Pendin Investi			3b, Time of 103 hrs		ury at Work? Yes 2 ✓	Driv	Describe ho er auto a			
Divisior Hospital or Attend 24 hours after death Funeral Director:	Sertific	3 Suicide 4 Homicide	6 Could a	not be			eet, factory, office y	building, etc		or Town, Sta	ite)		al Route Number, City Silver Spring, MD
To the Hos within 24 h To the Fun completely	Medical (sician: To the best of m ner: On the basis of examination manner stated.									
	Ň	29b. Signature and t	itle of certifier	ell ms			29c. Licen	se number .M.E.			29d. Date s July 30,		ith, Day, Year)
2 10		30 Name and addre Melissa Bras		ho completed cause of d Assistant Medical			Penn Street,	Baltimpre	, MD 212	01			
St	ate	31. Date filed (Month	Day Year)	32. Registra	's Signature	07							

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 25607 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^{2 ay} 2010^{ar} August 8:50 A M Stephen Nathaniel ABRAMS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Potomac Manor Care Potomac 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** Hours Min. July 17 Year) 1943 Months Pennsylvania Director 67 206-32-0774 Usual Residence of Deceden 28a-f shov 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County death with the Maryland Director 1 Yes 2 No Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20854 12500 Park Potomac Ave., #308N Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. ρ 1 Never Married 2 XMarried 3altimore, Maryland 21215-0036 within 72 hours after white If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Attorney Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ige 1 and 2 should be find of Health and Mental E: If item 27 is marked ဂ Ida Abrams Milton Romm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12500 Park Potomac Ave., #308N, Potomac, MD 20854 Judith Abrams, wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) Department o Important: If any injury or once. 08/03/10 Olney, MD Judean Memorial Gardens 4 Donation 5 Other (Specify) Signa Torchinsky Hebrew Funeral Home MOLUDB 20012 Carroll NWWashington DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Pnse and Death Immediate Cause (Final Physician/ Respiratory Failure disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 6 Months Glioblastoma Multiforme Sequentially list conditions, Examine Due to for as a consequence of it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Paransit . The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 H Unknown cate has been sig Completed 24b. Were autopsy findings available pnor to completion of cause of death? 24a. Was an has performex1? Yes 2 After this certificate 1 ☐ Yes 2 ☐ No or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

AUG

lomas

Thomas Masterson, M.D.,

03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10

29c. License numbe

D 50534

1313 Dolley Madison Blvd., #302, McLean, VA

29d. Date signed (Month, Day, Year) August 3, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 25608 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 30, Day 2010 Pear July Karen Patricia Allen-Pippin 7:23 p M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 12418 San Jose Lane Lusby Calvert 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 1 🗆 M 2 🕱 F Months Days Hours Min (Month, Day, Year) 7 1 9 5 7 Director 53 Yrs. 217-72-3591 DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director 28a-f MD Calvert Lusby 1 X Yes 2 No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 12418 San Jose Lane 20657 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ ☐ Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. 3 Widowed 4 X Divorced Completed White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry
Department of (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working filed within 72 tal Hyglene. Elementary/Seconday (0-12) College (1-4 or 5+) Financial Analyst the Navy 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked o မ Raymond Lee Allen permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic once. Zoe Pia Villone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tobi Phifer/Daughter 12418 San Jose Ln., Lusby, MD 20657 Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔲 Burial 2 💢 Cremation 3 🗆 Removal from State 8/9/10 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crem. Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Raymond-Wood F.H., P.A. PO Box 430, Dunkirk, MD 20754 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ LIVER CIRRHOSIS disease or condition resulting in death) en months Medical Due to (or as a consequence of) Examiner many years HEPATITIS Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 attending pl IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Yes signed by the a 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, HTM, SIP RENAL FAILURE PORTAL HY PERTENSION, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown 24a. Was an 24b. Were autopsy findings available has prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy page perform certificate Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No 1 Yes Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ours after death. 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

ARW IA
State
Registrar

PO BOX 1789

Registra s Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SCARIA MATHEW MD

31. Date filed (Month, Day,

D36969

LUSBY MD

812110

20657

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State of	iviai yiai	Cei	rtificate of L	Death	wientai n	Reg. N		25609
P	Physicia		1. Decedent's Name (First, Mid		istine B	Paka A	llovand	70		2. Date of D Month		0ay 2010	3. Time of Death 1600 M
	Medic Examin		4a. Facility Name (if not institut				renanu	1	r Location of Deat			c. County of Deal	
			Holy C7	1033 6. Se	Hospita		last birthday)	Sic.	lver Spr Tif Under 24 Hrs		list la		tgomery thplace (State or Foreign
	uneral irector		213-38-1748			Age (III yrs.		Months Days	Hours Min.		Day, Year)	28 Wasi	ungton. DC
and	show 1 at	ō	Usual Residence of Decedent 10a. State 10b. Cour	nty		10c. C	ity, Town or Lo	cation					10d. Inside City Limits
Maryl	28a-f lotified	irect	Maryland Priv	ice (Beorge's				Beltsvi	lle			1 Tes 2 X No
nd 21215-0036 filed within 72 hours after death with the Maryland al Horiene.	an "natural", or items 23a or 28a-f show Medical Examiner must be notified at	Funeral Director	10e. Street and Number 11224	Cher	vry Hill	Road.	Unit 102	10f. Zip Code	20705		10g. C	Citizen of What Co U.S.A	
r death	r item iner m		11. Marital Status 1 ☐ Never Married 2 ☐ N		12. Was Decede Armed Force	nt Ever in U s?		Was Decedent of H f Yes, specify Cuba	ispanic Origin? (S ın, Mexican, Puerl	pecify Yes or No to Rican, etc.))-	14. Race - Ame Black, White	
215-0036 in 72 hours after e.	ural", c I Exan	ed by	3 Widowed 4 🗷 Divorce		1 ☐ Yes 2 If Yes, Give Year or Dates			I ☐ Yes 2 🛭 No	Specify:			Specify:	White
15-(n "natı Aedica	Completed	15. Dece (Specify only hi	ghest gra	de completed)		(Give	dent's Usual Occup kind of work done o O NOT use retired)	ation during most of wo	rking	16b.	Kind of Business	Industry
212 within	other tha		Elementary/Seconday (0-12	2)	College (1-4 o	or 5+)		inistrat	ive Office	cer	Fe	deral Go	vernment
Maryland 21 2 should be filed with	6 g	To Be	17. Father's Name (First, Middle		um Packe	Real	oo Th		18. Mother's Na	me (First, Middle Lena			
ary hould b	s mark		19a. Informant's Name/Relatio			i Dear	7	ng Address (Street a	and Number or Ru				o Code)
	item 27 is marke		Maurine Blake 20a. Method of Disposition	Gang	loff/Si				rge Road,				<u>ryland 20904</u>
IIMOre, Page 1 and Iment of Hea	nt: If ite ry or of		1 Burial 2 Crematic 4 Departion 5 Othe					sition (Name of nators or other place CLEMAL) N_PAIK	12y 08/1	Date		Location - City or	Town, State , Maryland
ermit. F	Importa any inju		21. Signature of Funeral Service				22	. Name and Addres	ss of Facility H	ines-Ri	rald	i Funera	l Home, Inc.
ア	- 6 0	Н	23a. Part 1. Enter the disease,	or comp	lications that caus	sed the dea						<u>ver Spri</u>	ng, MD 20904 Approximate
~ Phys	sician/		shock, or heart failure. Lis Immediate Cause (Final disease or condition	st only or	e cause on each	line.	enic S						Interval Between Onset and Death
	ledical aminer		resulting in death)	C	Due to (or a	as a conseq	uence of):						
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	J	b. Due to (or a	epsis as a conseq	uence of):						
ecuted	g physician and s the burial-transit	Examiner	Cause (Disease or linjury that initiated events resulting in death) Last	1	c. Due to (or a		Cance	r		_			-
e be ex	ysician e buria	Medical I		L	d								
oo / oo	ling ph e as th		IF FEMALE:		23c. If yes, outcon	an of progra							
death ce	attend d for us	Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🔏 No	ĺ	1 ☐ Live Birt 4 ☐ Pregnan	h 2 ☐ Fet tat time of	aldeath 3 🗌	Ectopic pregnanc Other (specify)	у		Î	23d. Date of del Month	ivery Day Year
at the d	d by the		9 Unknown Part II. Other significant cond	itions co	9 Unknow		sulting in the u	nderlying cause give	ven in Part I	00- 0-1	4-1		Alternative of dental O
uires th	n signed	ed by	- Care in Care		Thirties and a doubt			nderlying cause giv					the cause of death?
COLUS,	as bee	Completed								24a. Was	s an opsy	prior to d	topsy findings available completion of cause of
L The	ficate h	e Cor	25. Was case referred to medic	al I				00 PJ	(D. 11.40)	1 Tes	formed? 2 X N	death?	2 🗆 No
VICAL	is cert direct	10 B	examiner? 1 ☐ Yes 2 🏋 No		lospital:	atient 2 🗆	ER/Outpatien	Otho	ace of Death (Che		idence	6 ☐ Other (Speci	ify)
ding Pt	After th funeral		27. Manner of Death 1	ding stigation	28a. Date of in (Month, I		28b. Time of injury	28c. Injury work M 1	at	28d. Describe			2/
DIVISION OF VICE BOX 66/100 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	Director: in by the	Certificate:	3 🔲 Suicide 6 🗆 Cou		28e. Place of I	njury - At ho etc. <i>(Specif</i>)		et, factory, office	2 2 110	28f. Location (nd Number or Rur e)	ral Route Number,
ospital hours	d filled	Medical (29a. Certifier 1 🔀 Certifyi	ng Physi	cian: To the best	of my know	ledge, death o	ccured at the time,	date and place, a	and due to the c	ause(s) a	ınd manner as sta	ted.
the Hithin 24	orthe Fr		(Check 2 Medica only one) 3 Certifyi 29b. Signature and title of certifyi	ng Nurse	Practioner: To the	ne best of m	n and/or investi y knowledge, d	eath occurred at the	e time, date and pla	at the time, date ace, and due to t	he cause	(s) and manner as	
6) /	1	Chan			-000	5305		zau. Di	ate signed (Month	24, 2010
			30. Name and address of person Nabila Farhat						l, Silve	r Spring	, Ma	aryland	20910
R	Stat Registra		31. Date filed <i>(Month, Day, Year,</i> JUL 30			trar's Signa							
	registra	1	JUL 30	401	U KRIBU	as for							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 25610 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2010 Physician/ July Geneva Elease Bowling 9:00 Рм 29 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince George's Hospital Prince George's Cheverly . Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Months Days Hours August, 20. 66 1943 Virgin<u>ia</u> 226-56-7076 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City. Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director Capitol Heights Prince George's MD 1 X Yes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? 23a Funeral 539 Opus Avenue 20743 U.S. items ? 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. African American P, <u>ک</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🕅 No Specify: "natural" Completed 3 XWidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. within 7 Elementary/Seconday (0-12) College (1-4 or 5+) Education 12 Day Care Provider Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve မ Paul Turner Lottie Turner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shelly Toliver-Daughter 539 Opus Avenue, Capitol Heights, MD 20743 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 8-7-10 Roseland, A Virginia 4 ☐ Donation 5 ☐ Other (Specify) Bowling Family Cemetery 21. Signature Juneral Service Licenses 22. Name and Address of Facility Bonnette & Assoc. Funeral Hm 2504 28th St., N.E., WDC 20018 26a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of aying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each in e. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 Youths? 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) signed by the aid be detached t 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Tes 2 No 3 Probably 4 Unknown certificate has been s rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 IS No Vital completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: မ npatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this Division of Date of injury (Month, Day, Year) 27. Mahner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work?
1 Yes 2 No Investigation s after death Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifier 29d. Date signed (Month. Da. 2

State Registrar

10

30. Name and address

James Catevenis

Cheverly

person who completed cause of death (Item 23a) (Type, Print)

32. Registra

3001 Hospital Dr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

	-	For State of Ma		artment of Hea tificate of Dea		-	ene 2010	25611
Physicia	an/	1. Decedent's Name (First, Middle, Last)			2	. Date of Death Month	n Dav Year	3. Time of Death
Medic Examir	cal	J. ALLEN BC 4a. Facility Name (if not institution, give street and number)	WERS	4b. City, Town, or Loca	ation of Death	AUG.	1, 2010 4c. County of Deat	11:33 A ^M
	ici	HOLY CROSS HOSPITAL			VER SPRI		MONTGO	
Funeral Director			e (In yrs. last birthday) 88 Yrs.		Under 24 Hrs. 8 ours Min.	Date of Birth (Month, Day, AUG. 8	year) 9. Birt Cor 1921 MA	hplace (State or Foreign untry) RYLAND
and show at	ō	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	cation				10d. Inside City Limits
Maryla 28a-f s otified	rect	MD. PRINCE GEORGES	AD	ELPHI				1 Yes 2 ☐ No
death with the Maryland r items 23a or 28a-f sho iner must be notified at	Funeral Director	10e. Street and Number		10f. Zip Code		1	0g. Citizen of What Co	·
ath wil	uner	3405 CHATHAM RD. 11. Marital Status 12. Was Decedent E	ver in U.S. 13. V	2078 Was Decedent of Hispan	ic Origin? (Specif	y Yes or No-	U.S.	
ING Z1Z13UU30 s filed within 72 hours after death with the Maryland tal Hyglene. sd other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married Armed Forces?	No	f Yes, specify Cuban, Mo 1 ☐ Yes 21⁄2 No Sp	exican, Puerto Ric	can, etc.)	Black, White	e, etc.
ZTZT5-0U30 within 72 hours after glene. er than "natural", or the Medical Exami	Completed	3 Widowed 4 Divorced Year or Dates.	16a. Deced	dent's Usual Occupation			16b. Kind of Business	ITE Industry
CLZ:	dwc	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5	+) life. Di	kind of work done during O NOT use retired)	g most of working	1		
nd 21 filed with al Hygien d other the	Be C	17. Father's Name (First, Middle, Last)	P	RODUCER	Mother's Name (First Middle M	PUBLIC TE	ELEVISION
	일	CLAUDE BOWERS)	10.	ED.		DAVIS	
Maryl should and Me		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and N	Number or Rural F	Route Number,	City or Town, State, Zip	o Code)
re, Maryla t and 2 should be f Health and Men trem 27 is marke other traumatic		ELIZABETH B. BOWERS/WIFE 20a. Method of Disposition	3405 20b. Place of Dispo	CHATHAM RD	ADELP		20783 20c. Location - City or	Town State
Page 1 Thent of 0		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cemetery, cren	matory or other place) CREMATORY	8-2-2		RIVERDALE,	
Baltimore, permit. Page 1 and Department of Hea Important: If item; any injury or other		21. Signature of Funeral Service Gensee	22	Name and Address of CHAMBERS FUL	Eacility NERAL HO	ME & CR	EMATORIUM,	P.A.
		23a. Part 1. Enter the disease, or complications that caused	the death. Do not ente	801 CLEVELA er the mode of dying, su				Approximate
- Physician/	Н	shock, or heart failure. List only one cause on each line Immediate Cause (Final	CARDIAC DE					Interval Between Onset and Death
Medical Examiner		resulting in death) Due to (or as a	a consequence of):					
	_	Sequentially list conditions, If any, leading to immediate	IC CARDIOM	IYOPATHY				
executed an and rial-transit	Examiner	that initiated events C. —————	RY ARTERY D	DISEASE			ij.	
	iğ E	resulting in death) Last Due to (or as	a consequence of):					
certificate be anding physiciluse as the bu	l edical	d						
Ords, P.O. BOX 687, vequires that the death certific been signed by the attending I should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
that the ned by the detack	by Ph	Part II. Other significant conditions contributing to death b	ut not resulting in the u	underlying cause given in	n Part I.	23e. Did tob	acco use contribute to	the cause of death?
dS, I quires 1 en sign						1 □ Ye	es 2 🗆 No 3 🗔 P	robably 4 🔀 Unknown
n of Vital Kecords, P.O. Box ding Physician: The law requires that the death h. After this certificate has been signed by the atte funeral director, page 2 should be detached for	Completed				***	24a. Was ar autops perform 1 Yes 2	y prior to death?	topsy findings available completion of cause of
ian: T	Be C	25. Was case referred to medical examiner?			of Death (Check o		25 1101	
Physic Physic this or ral dire	은	1 Yes 2 No Hospital: 1 Yes 2 No 1 No	ent 2 ER/Outpatier ry 28b. Time of				nce 6 Other (Spec	cify)
on o	icate	1 X Natural 5 ☐ Pending (Month, Day 2 ☐ Accident Investigation	v, Year) injury	work?	2 🗆 No		,,	
Division of Vital tal or Attending Physiciam: a after death. al Director: After this certific ed in by the funeral director.	Certificate:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injubuilding, etc.	ury - At home, farm, str c. (Specify)	eet, factory, office	28	3f. Location (Str City or Town	reet and Number or Ru , State)	ıral Route Number,
To the Hospital or Attending Powithin 24 hours after death. To the Funeral Director. After the completed filled in by the funeral	Medical	29a. Certifier 1 X Certifying Physician: To the best of (Check 2 Medical Examiner: On the basis of e	xamination and/or inves	itigation, in my opinion, de	eath occurred at th	ne time, date an	d place, and due to the	cause(s) and manner stated.
Го the within 2 Го the сотрlе	ž	only one) 3 Certifying Nurse Practioner: To the 29b. Signature and tile of certifier	best of my knowledge,	29c. License nur			cause(s) and manner as 9d. Date signed (Mont	
1+1) of one		D63	639		8 Ialu	0
		30. Name and address of person who completed cause of d	. 1500 FC	REST GLEN	RD., SIL	VER SPE	RING, MD. 2	20910
Sta Registr		31. Date filed (Month, Day, Year) AUG 03 2010	ar's Signature	w.				
		11						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend State of Maryland / Department of Health and Mental Hygiene 0 | 0

25612 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Year 2010 7:33 PM Thomas Bell Jul Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Regional Hospital Prince aurel George's dure! 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 9<u>53</u> 1 🖾 M 2 🗆 F South Carolina **Director** 56 Yrs. Usual Residence of Decedent 10b. County at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director event, the Medical Examiner must be notified 28a-f 1 X Yes 2 No Laurel Maryland Prince George's 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? 23a by Funeral 20708 United States 8499 Imperial Drive within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Force Black, White, etc. ō 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 1 Yes 2 No Specify: Specify: African "natural", If Yes. Give 3 Divorced 4 Divorced Completed American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12th Contractor Self-Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked o ည should be Roger Bell, Jr. Mattie Wingate other traumatic and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 shament of Health a tant: If item 27 is 8499 Imperial Drive Laurel, Maryland Anne S. Bell/ Wife Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 s
Department of H
Important: If ite
any injury or ot ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Lee's Crematory Aug.9,2010 Clinton, Maryland Signature of Funeral Service Licen 22. Name and Address of Facility Stewart Funeral Home, Inc. once. 4001 Benning Road NE Washington, DC 20019 23a. For 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death

1 Hour Physician/ Acute Myocardial Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Dini to for as a nonsecuence of physician and s the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical requires that the death certificate be Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 5 Other (specify) Yes 2 No signed by the a d be detached f 1 ☐ Yes ∠ ☐ 9 ☐ Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law has autopsy page ; performed certificate 1 🗌 Yes 2 🗌 No Yes rector, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XNo မ 1 Inpatient 2 KER/Outpatient 3 IDOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After the completed filled in by the funeral Natural Accider work? 5 Pending Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title 29c. License number 29d. Date signed (Month. Day, Year) D 23685 27, 2010 Regional Hospital, Emera aurel, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hammond Laurel 32. Registra 's Sign State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 25613 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 08/02/2010^a 3:52 a M Gave Marie Brodigan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sunderland 1201 Lake Ridge Drive Calvert 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days Min Country) 1 🗆 M 2 屎 F (1870 09 / 1943 MD 577-58-3752 66 Director Usual Residence of Decedent show 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. In the Maryland is the 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 Tes 2 X No Sunderland MD Calvert 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 20689 1201 Lake Ridge Drive 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: If Yes, Give Year or Dates Specify: White 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Dermatologist Insurance Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Florence L. Nalley James E. Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Brodigan/Husband 1201 Lake Ridge Drive, Sunderland, MD 20689 20b. Place of Disposition (Name of cemetery, crematory or other place)
Resurrection Cemetery 08/06/2010 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 X Burial 2 Cremation 3 Removal from State Clinton, MD 4 Donation 5 Other (Specify) 21. Signatur of Funeral Servi 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. Lisa M. Mounts 8125 Southern Md Blvd., Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer P Wisters Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Other (specify) IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown igned by the atte Month Dav 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 2 should has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page, perform 2 No this certificate 1 Yes within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, 26. Place of Death (Check only one, 25. Was case referred to medical Be examiner? Hospital: Other: 2 No မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: Manner of Death 28c. Injury at 28d. Describe how injury occurred iniury 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Cheq Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signa 29d Date signed (Month, Day, Year) Name and address drw 10 32. Registra State AUG Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / E		nent of F cate of L			2	010	25	614
			Registrar 1. Decedent's Name (First, Middle, Last)	Certino	ale of L	Jeani	2. Date of Dea	neg. Ito.	310	3. Time of	
	Physicia Medic		Donald F. Bannon				July 29		Year	3:40 A	
A	Examin		4a. Facility Name (if not institution, give street and number) 8879 Indian Springs Road	4b. (Location of Death	1		nty of Death cederi	ck	
	Funeral Director			hday) If U Yrs. Mon	Inder 1 Year oths Days	If Under 24 Hrs. Hours Min.	8. Date of Bird Feb 21			place (State o	
	nd how at	٦٢	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location						10d. Inside Ci	ity Limits
	Aaryla 8a-f s tified	recto	Maryland Frederick Freder	rick							2 x No
	with the N 23a or 2 1st be no	Funeral Director	10e. Street and Number 8879 Indian Springs Road		f. Zip Code 21	.702		10g. Citizen o		ntry?	
036	be filed within 72 hours after death with the Maryland ental Hygiene. Ked other than "natural", or items 23a or 28a-f show ie event, the Me Ical Examiner must be notified at	by	11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 S Yes 2 No If Yes, Give Year or Dates.	If Yes,	ecedent of Hi specify Cuba es XX No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)		ace - Americ lack, White, ify: wh		
2-C	2 hour	plet		Decedent's		ation during most of wor	kina	16b. Kind of	Business In	dustry	
121	ithin 7 ene. • than	Completed	Elementary/Seconday (0-12) College (1-4 or 5+)	life. DO NOT	Tuse retired)	Manager	•	ī	J.S. G	overnm	ent
מ	iled w I Hygi other rent, t	Be	17. Father's Name (First, Middle, Last)	- Innum re		18. Mother's Nan		_		0 1 0 1 1111	
ylar	should be file n and Mental I 7 is marked o raumatic eve	욘	Unknown			Ur	nknown				
, Maryland 21215-0036	age 1 and 2 should be ont of Health and Ments it: If item 27 is marked y or other traumatic e					and Number or Rui Springs R					21702
baitimore,	permit. Page 1 an Department of He Important: If iten any injury or othe once.		I Dunial 2 La Oremation 3 Li Removal nom otate	Disposition ry, crematory fer Cr	or other plac		Date -2010	20c. Locatio	-		nd
alt≡	rmit. P partm portar y injur		21. Signature of Funeral Service bicensee		e and Addres	7 :	tauffer				iiu .
<u>n</u>	9 9 m m 9		Sharow Camelle muth			umtown P	ike, Fre	ederick			2170
7	Pnysician/ / Medical Examiner	er	23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of Due to (or as a	Cy		g, such as cardiac	or respiratory arr	est,		Approximat Interval Bet Onset and I	ween Death
00/	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.	edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of C								
. DOX 00	e death certific the attending ched for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	3 ☐ Ecto	pic pregnanc r (specify)	у			Date of delive	,	⁄ear
, ,	es that th signed by I be detac		Part II. Other significant conditions contributing to death but not resulting in	the underly	ing cause giv	ren in Part I.		bacco use co			
ecolus,	requii been should	lete	angrexico.				24a. Was a			psy findings a	
ב ב	: The lav cate has ; page 2	Completed by					autop perfoi 1 🗌 Yes	med?	prior to coldeath?	mpletion of c	ause of
2	sician certifi irector	m	25. Was case referred to medical examiner? 1 Ves 2 PNo Hospital: 1 Inpatient 2 FB/Out		Otho	ace of Death (Chec					
5	ding Phys th. After this funeral d	cate: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of injury (Month, Day, Year) inj		28c. Injury work	4 ☐ Nursing H	ome 5 Resid 28d. Describe h			")	
UNISION	al or Atten s after dea I Director: d in by the	Certificate:	2			163 2 2 110	28f. Location (S City or Town		ber or Rural	Route Numb	er,
	le Hospita n 24 hours le Funera pleted fille	Medical	29a. Certifier (Check conly one) 1	r investigation	n, in my opinio	n, death occurred a	it the time, date ar	nd place, and o	due to the cau	use(s) and ma	nner stated.
	Vithir Vorth		29b. Signature and title of certifier		29c. License	number		29d. Date sign			
			hope		000	6769,		7.29.	10.		
,	1		30. Name and address of person who completed cause of death (Item 23a) (Ty Mark Goldstein, M.D. 501 W. Se		Stree	t. Frade	rick. Ma	rvland	2170	0.1	
(+IVA Stat	e	Mark Goldstein, M.D. 501 W. Se 31 Date filed (Month, Day, Year) 32 Registrar's Signature	A A	Price	c, rrede	LICK, Flo	- y Land			
	Registra	_	31. Date filed (Month, Day, Year) AUG 2 20 32. Registrar's Signature	3. 140	wer						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	Ce	ertificate of D	eath	Reg.	no2010	25615
	Physic	an	1. Decedent's Name (First, Middle, Last)				Date of Death Month	Day Year	3. Time of Death
	/Medi		William Robert E				August 5,		12:40 A M
	Exami	ner	4a. Facility Name (If not institution, give street and num 10686 Greensboro Road	nber)	4b. City, Town, or L			4c. County of Death	
				7. Age (In yrs. last birthday	Den	TON If Under 24 Hrs.	8. Date of Birth	Carol	
	Funeral Director	Н	218-20-4943	83 Yrs.	Months Days	Hours Min.	(Month, Day, Yes		place (State or Foreign intry)
	TO .		Usual Residence of Decedent				wovember 10,	1926 Mar	yrand
	arylar show	_	10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits
	8a-f	Director	Marylnad Caroline	Den					1 □Yes 2 □ No
	a or a	ä	10e. Street and Number 10686 Greensboro Road		10f. Zip Code		-	Citizen of What Cou	
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ont, the Mexical Exactive etroust be notified at	Funeral		dent Ever in U.S. 13.	Was Danadart of Hist	ania Origin? (Eng		T	s of America
(0	fter d	Fu	Armed For	ces?	Was Decedent of Hisp If Yes, specify Cuban,	, Mexican, Puerto I	Rican, etc.)	14. Race - Ameri Black, White,	
036	urs a	by	1 ☑ Never Married 2 ☑ Married 1 ☑ Yes 3 ☑ Widowed 4 ☑ Divorced Year or Da	e ites:	1 ☐ Yes 2 ☑ No	Specify:		Specify: Ca	ucasian
21215-0036	72 ho natur lical	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	edent's Usual Occupati	ion	16b.	. Kind of Business/Ir	
21	within lene. than "	du du	Elementary/Secondary (0-12) College (1-	40r5+)	kind of work done du DO NOT use retired)	ning most of workin	_	'reight	
	filed w Hygie ther ti		17. Father's Name (First, Middle, Last)	Tru	ıck Driver			ansportat	ion
anc	ould be fi Mental I arked of atlc ever	Be		oaker			(First, Middle, Maid	•	
Maryland	2 should and Mer Is marke surnatic	ို	19a. Informant's Name/Relationship (Type. Print)		ing Address (Street an		te Anise		- 0-4-1
Ma	0 07 -	1	Elva Brubaker Wif		6 Greensbo				21629
Ē,	s t and 2 of Health Item 27 I		20a. Method of Disposition	20b. Place of Disp	osition (Name of matory or other place)			Location - City or T	
E	Pages nent of I ant: If Ite ury or of		1 □ Burial 2 □ Cremation 3 □ Removal from S 4 □ Donation 5 □ Other (Specify)	itate	Cemeterv	8/9/	2010 Da	M	1 1
Baltimore,	permit. Pages t a Department of Hec Important; if Item any Injury or othe once.		21. Signature of Funeral Service Licenses	2 Defreoir	2. Name and Address	of Facility Moc	reFuneral	nton, Mar lHome, P.	yland .
<u> </u>	89 7 6 8		(Kandoph P. (//c		2 South Sec				
	Physician /Medical Examiner	Examiner	Sequentially list conditions.	to hine. RDAC or as a consequence of): CIFRO or as a consequence of):	FALLUR	E		05	Approximate Interval Between Onset and Death WEEKS
68760,	eath certificate be executed attending physician and for use as the burial-transit	Medical Exa	Due to (c	or as a consequence of):					
.O. Box	the d y the iched	Physician/IV	in the past 12 months?	ant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of deliv Month	rery Day Year
ords, P.	v requires that been signed b should be deta	by	Part II. Other significant conditions contributing to dea	ath but not resulting in the u	nderlying cause given	in Part I.		o use contribute to t 2 ☐ No 3 ☐ Pro	he cause of death?
	The law ate has b page 2 st	• Completed	25. Was case referred to medical				24a. Was an autopsy performed? 1 □ Yes 2 €1	prior to co	opsy findings available impletion of cause of
Š	Physician: this certific ral director,	m	examiner?	patient 2 ☐ ER/Outpatie	Othori	6. Place of Death			
		n: To	27. Manner of Death 28a. Date o	Injury 28b. Time of	f 28c. Injury a		e 5 Residence 8d. Describe how in	6 ☐ Other (Speci	fy)
ion	Attending I r death. ector: After by the funer	aţio	1 ■ Natural 5 Pending (Month 2 Accident investigation	, Day, Year) Injury	Work?	s 2 □No		,,	
É	ital or Atten	Certification:	3 Suicide 6 Could not be determined 28e. Place of building	of Injury - At home, farm, str g, etc. <i>(Specify)</i>	eet, factory, office	21	Bf. Location (Street City or Town, Sta	and Number or Run ate)	al Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical	29a. Certifier (Check only (e) (be) 1 Certifying Physician: To the ba 2 Medical Examiner: On the ba and manner	sis of examination and/or ir	h occurred at the time, vestigation, in my opin	, date and place, a lion, death occurre	nd due to the cause d at the time, date a	e(s) and manner as and place, and due to	stated. o the cause(s)
	To the within 2 To the comple	Σ	296/Signature and title of certifier	11 Omp	29c. License n		29d. [Date signed (Month,	Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Christian E. Jensen, M.D., PO Box 690, Denton, Maryland 21629 31. Date filed (Month, Day, Year)

State Registrar

AUG 0 8 2010



5t DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 25616 Reg. No 2 0 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 29 Physician Gladvs M. Baker-Grimes July 2010 3:25 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Caroline Homestead Manor Denton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 13 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. Days 1 □ M 2 🔀 F Months Hours 78 Director 575**–**28**–**8782 Hawaii Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 28a-f show 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Examiner must be redified at 1 □Yes 2 X No Director Maryland Caroline Denton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 25751 Garey Road 21629 Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ♣No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 □ Never Married 2 □ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 X No White If Yes, Give Year or Dates: Specify. þ Specify. 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Depart of Transport. operation technician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be n and Mental F Toshio Takahashi Tomiko Mizuno 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health in tem 27 is Lorna Baker/ daughter 25751 Garey Road; Denton, Maryland 21629 20b. Place of Disposition (Name of cemetery, crematory or other place) Cn 20c. Location - City or Town, State 20a. Method of Disposition Department of F Important: If ite any Injury or ot once, 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Chesapeake Cremation 07/31/10 4 ☐ Donation 5 ☐ Other (Specify) Chester, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility PO Box 160; Greensboro, Fleegle and Helfenbein Funeral Home, PA MD 21639 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ancreatic Cancer disease or condition resulting in death) /Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician: The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregrant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Day 5 Other (specify) signed by the a P.0. ☐Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed' 2 No 1 □ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) A35,540 Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this after death.

I Director: After this d in by the funeral di 27. Mann f Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation 1 ☐ Yes 2 🗌 No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier CIMI 0005325

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

 \mathcal{S}'

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 0 25617 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 8 William Clement Birely, Sr. 2ď 🖺 0 8:40 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1517 Shad Row Ocean City Worcester 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country)

MD 1 XM 2 □ F Months Days Hours Month, Day, Year 11111920 Director 212-07-4288 90 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits be notified 28a-f 1 X Yes 2 ☐ No MD Worcester Ocean City 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 1517 Shad Row 21842 USA 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner 14. Race - American Indian rmed Forces? Black, White, etc. 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene.

item 27 is marked other than "natural", or ģ 1 Never Married 2 X Married ō Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced Specify. white event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Distribution & Transport Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Harry C. Birely Kathryn McKelvey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Birely / son 215 Lake Dr., Rehoboth, DE 19971 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of I Important: If it any injury or of 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State Sunset Memorial Park 8/5/2010 Berlin, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature ral Service Licensee 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. P 1 Enter the disease, or complications that caused oo , or heart failure. List only one cause on each line Approximate Interval Between Immediate Cause (Final Physician/ Vebilit Onset and Death disease or condition Medical resulting in death) Due to (or as a nsequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) physician a the burial-Physician/Medical that the death certificate be Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Dav Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Records, Completed No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy certificate Yes Hospital or Attending Physician: Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner¹ Hospital: 1 🗌 Yes ျ 1 Inpatient 2 ER/Outpatient 3 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manger 🥖 Certificate: eath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? Natural 5 Pending nours after death.

neral Director: Af 2 Accident Investigation Suicide Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated a Certifying Nurse Practioner: The best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) BA 20+1 busil State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State		State o	f Mary	land / I		artment of H		and M	/lental Hy	ygiene	010	05610
	_	State Registrar 1. Decedent's Name (First, Mi	1-11- 1-0				Cer	tificate of L	Death			Reg. No	010	25618
Physicia		i. Decedent's Name (First, IVII	aale, La	Ann M	laria	Rurr					2. Date of D Month	Dav	2010	3. Time of Death
Medic Examin		4a. Facility Name (if not institu	ion, give			Dull		4b. City, Town, or	Location	of Death	August	7	2010 ounty of Death	0720 A ^M
		Union Hospit	a1					Elktor					Cecil	
Funeral		5. Social Security Number	6. 5	Sex I □ M 2 👿 F		yrs. last birt		If Under 1 Year Months Days	If Under	r 24 Hrs. Min.	8. Date of Bi	irth	9. Birth	place (State or Foreign
Director		219-74-7378 Usual Residence of Decedent		- ··· - X	46		Yrs.				May 27	7, 1964	4 Ma	ryland
and show	ŏ	10a. State 10b. Cou	nty		100	:. City, Towr	or Loc	ation		-				10d. Inside City Limits
the Maryland or 28a-f show e notified at	irec	Maryland Ce	ci1			E1kt	on							1 🏋 Yes 2 □ No
th the 3a or t be n	a D	10e. Street and Number						10f. Zip Code				10g. Citizer	n of What Cou	ntry?
ath wi	ıner	233 Courtney	Dri		lant E	11.0	Tan is	21921					nited S	States
er dez or ite	y F	11. Marital Status1 X Never Married 2 □ !	/larried	12. Was Dece Armed For 1 Yes	ces?	n U.S.		las Decedent of Hi Yes, specify Cuba			cify Yes or No Rican, etc.)	- 14.	Race - Ameri Black, White,	
03(rs aft rral",	ed k	3 Widowed 4 Divor		If Yes, Give Year or Da	9		1	☐ Yes 2 🗓 No	Specify	:		Spe	_{ecify:} Whi	te
2 hou	Completed by Funeral Director	15. Dece (Specify only hi	dent's E	ducation ade completed)		16a.	Deced	ent's Usual Occupa ind of work done d	ation	t of working	na	16b. Kind	of Business In	
thin 7 than the Me Me	Com	Elementary/Seconday (0-1		College (1-	4 or 5+)		life. DC	NOT use retired)	_		<i>'</i> 9	,,,	1.1 6	
led w led w other ent, t	Be	17. Father's Name (First, Middle	e, Last)	4			ке	gistered			(First, Middle		ealth C	are
ore, Maryland 21215-0036 1 and 2 should be filed within 72 hours after death with the Maryland 1 frem 27 is marked other than "natural", or items 23a or 28a-f sho 1 item 27 is marked other than "natural", or items 23a or 28a-f sho 1 other traumatic event, the Medical Examiner must be notified at	욘	Paul M. Burr									t Mary		•	
lary should and N is ma		19a. Informant's Name/Relation	nship (7	ype, Print)		19b.	Mailin	g Address (Street a						Code)
b, N und 2: lealth im 27		Paul C. Burr	'Bro	ther		2	52	Irishtown	n Roa	d, No	orth Ea	ast, MI	2190)1
		20a. Method of Disposition 1 ሺ Burial 2 🗆 Cremati			State T	ob. Place of cemeter	Dispos y, crem	ition (Name of atory or other place	9)	Augus	oate St 6,	20c. Locat	tion - City or To	own, State
Baltimo		4 Donation 5 Othe		-	1 6	oncep	tio	atory or other place e n Cemete	ry .	2010		Che	erry Hi	11. MD
Balti permit. Departr Importa		21. Signature of Patheral Service	e Licens	H.	0,0		22.	Name and Addres						
		23a. Part 1. Enter the disease shock, or heart failure, Li	or com	plications that ca	aused the d	death. Do n	ot enter						LOII, FIL	Approximate
Physician/		Immediate Cause (Final disease or condition	st Offig O	He cause on each	out	FE	110	10						Interval Between Onset and Death
Medical Examiner		resulting in death)		a. Due to (r as a cons	sequence o	f):							
	e e	Sequentially list conditions, if any, leading to immediate		b. Alc	ohol	sequence o	se							
nsit ed	盲	Cause (Disease or iinjury	<	Due to (c	i as a cons	sequence o	1):							
execu	Ĕ	that initiated events resulting in death) Last	1	Due to (c	r as a cons	sequence o	f):							
'60 ate be executed bhysician and the burial-transit	dical Examiner		L	d										
6870 certifica certifica certifica	Ě	F FEMALE:	T	00- 16								_		
Records, P.O. Box 687 The law requires that the death certifica are has been signed by the attending page 2 should be detached for use as the state of the state the state	Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months?		1 Live B	ome of pre irth 2	Fetal death	3 🗆	Ectopic pregnancy Other (specify)	/			23d	. Date of delive	ery Day Year
he de y the sched	hysi	1 Yes 2 No 9 Unknown		9 Unkno		or death	υ	Other (specify)					WOTH	Day real
P.O. that the ned by the detach	y P	Part II. Other significant cond	tions co	ontributing to de	ath but not	resulting in	the un	derlying cause give	en in Part I	l.	23e. Did t	obacco use c	contribute to th	ne cause of death?
ds, quires en sig	ed	Regatorenal	54	ndrome							1 🗆	Yes 2 🐼 N	lo 3 🗆 Prot	oably 4 🗆 Unknown
tal Records, sian: The law requires ertificate has been signor, page 2 should b	nple.	,									24a. Was			osy findings available mpletion of cause of
Recate I The											perfo	rmed?	death? 1 🔲 Yes	·
of Vital Physician: this certific	ĎΙ	25. Was case referred to medic examiner? 1 ☐ Yes 2	_	Hospital:						th (Check o	only one)			
of V	<u> </u>	27. Manner of Death		28a. Date of	f injury	ER/Out		3 DOA 28c. Injury	_4 ∐ Nu		ne 5 Residente Residente Propinsion de la Residente Residente Residente Residente Residente Residente Residente		Other (Specify))
on o	icat	1 Natural 5 Pen 2 Accident Inve	ding stigation		, Day, Year,) in	ury	work?		- 1	od. Describe i	low injury occ	corred	
Division of Division of all or Attending Pheater death. In Director: After the did by the funeral	Certificate:	3 Suicide 6 Cou 4 Homicide dete	d not be mined	28e. Place o	f Injury - A	t home, farr	n, stree	t, factory, office		2			mber or Rural	Route Number,
Diving a filled in lifted in		(C)									City or Tow			
Division of Vital Reco Division of Vital Reco To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s	Medical	Check 2 L Medica	∟cxamıı	ner: Un the basis	of examina	ation and/or	investic	cured at the time, ation, in my opinion	doath oc	Curred at the	ha tima data a	nd place and	dura ta Aba aa.	L-4-4- u
To the within To the sompl		only one) 3 L Certifyi 29b. Signature and title of certifyi		e Practioner: 10	the best o	my knowle	dge, de	ath occurred at the		and place,			d manner as sta gned (Month, E	
		Ken (e	K	7 Ph	1(:,	<u></u>		769	045	2		/	12010	
~	ŀ	0. Name and address of person						nt)				37-	/~-	
2		Kerry Lecker 11. Date filed Month, Day, Year,	i	106 Box	J 5+	reet	E	1k ton	WD	21	1921			
State Registrar		AUG 1 7 20	n	32. Reg	gistrar's Sig	nature	Na							
DUMINATE 7/000	0		. 0	-		1			_		-			

1X Yes 2 No 1942 If Yes, Give Year or Dates: −1945

1 ☐ Yes 2 ☐ No 10q. Citizen of What Country? U.S.A. 14. Race - American Indian Black, White, etc.

Specify: White

Millington, MD.

16b. Kind of Business/Industry

2010

Kent

4c. County of Death

1922

6:15 pM

Birthplace (State or Foreign Country)

10d. Inside City Limits

Maryland

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 17. Father's Name (First, Middle, Last)

Troubleshooter Electric Company 18. Mother's Name (First, Middle, Maiden Surname)

2. Date of Death

AUGUST

Harry Bottomley 19a. Informant's Name/Relationship (Type. Print)

1 ☐ Never Married 2 ☐ Married

3 ₩ Widowed 4 Divorced

Agnes Pinion 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Kevin Bottomley (son) 20a. Method of Disposition **IX** Burial 2 ☐ Cremation 3 ☐ Removal from State

210 Pfalzgroff Rd. Millington, MD. 21651 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State

8/12/10

Asbury Cemetery 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License M00510

Galena Funeral Home of Stephen L Schaech 118 West Cross St. Galena, MD.

Immediate C use (Final disease or condition resulting in death)

1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. interction Myopathia Due to (r as a consequence of):

1 ☐ Yes 2 █XNo

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Specify:

Approximate Interval Between Onset and Death O Min.

Sequentially list conditions, if any, leading to infine liate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

mover Due to (or as a consequence of) Atrial Due to (or as a consequence

IF FEMALE

23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 3 ☐Ectopic pregnancy

23d. Date of delivery Month

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

SOYTIC

aneur,

24a. Was an autopsy performed Yes 2 1∐ Yes

24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 🗌 Yes

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital: 1 ☐ Inpatient 2 ER/Outpatient

and manner stated.

3□ DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

27. Manner of Death T Natural 5 ☐ Pending investigation 2 Accident 6 Could not be 3 ☐ Suicide

28a. Date of Injury (Month, Day Year) 28b. Time of Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury at Work? 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

26. Place of Death (Check only one)

29b. Signature and title of certifie

 $c_{\mathcal{M}}$ U0051735 29d. Date signed (Month, Day, Year)

30. Name and odress of person who completed cause of death (Item 23a) (Type, Print)

Frederick Delboy, M.D. 6602 Church Hill Rd. Chestertown, MD. 21620

Registrar

31. Date filed (Month, Day, Year) AUG 172010 32. Registrar's Signatur

To the Hospital or Attendin within 24 hours after death.

Baltimore, Maryland 21215-0036

"natural", or

permit. Pages 1 and 2 should be filed. Department of Health and Mental Hygis Important: If item 27 is marked other any injury or other traumatic event, ±1

Physician

/Medical

Examiner

sician and burial-tran

attending physician for use as the buria

ed by the a

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760

Examine

Physician/Medical

þ

Completed

Be

Certification: To

Medical

þ

Completed

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 25620 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Month **Physician** 201 /Medical 4c. County of Death a. Facility Name (If not institution, give street and m 4b. City, Town, or Location of Death Examiner If Under 1 Year Birthplace (State or Foreign Country) If Unde Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Min. 1 □ M 2 😾 F 6/26/1920 Pennsylvania 90 Director 205-16-6759 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County works 1 ☐ Yes 25No יט orner man "natural", or Items 23a or 28a-f sl event, ibu Medical Examinar must be notified Director Harford MD Whiteford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2654 Whiteford Road 21160 USA 72 hours after death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify. Black þ 3√2 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation. (Give kind of work done during most of working life. DO NOT use retired) filed within 7 I Hygiene. other than "n Elementary/Secondary (0-12) College (1-4or 5+) Own Home Department of Health and Mental Hygien Important; If item 27 is marked other the any Injury or other traumatic Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alice B. Dorsey Gilpin Rice ္က 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia Brown/Daughter Perriwinkle Court, Dover, DE 19904 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Trinity Cemetery 8/7/2010 Delta, PA 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA Lover Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease or com shock, or heart failure List only complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Sup to for self-consequence off Examiner be execute and burial-t Due to (or as a consequence of): attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) Yes 2 No 9 Unknown 9 Unknown signed by 1 1 be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performed? Yes 2 No certificate 2 🗆 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Many er of Death 1 Natural funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 □Yes 2 □No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

P.0. Records. Division of Vital e Hospital or Attending Physician: 24 hours after death.
Funeral Director; After this certifica completely within 2

29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0066958 Name and address of person who completed gause of de

Registrar

31. Date filed (Month, Day, Year)

and manner stated-

10-05948 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Deborah Burgess-Smith State of Maryland / Department of Health and Mental Hygiene 2010 25621 1- For State Certificate of Death Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ **Medical Examiner** 2131 hrs DEBORAH ELAINE BURGESS-SMITH August 7, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Street 1532 Clearview Drive Harford 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Days Months Hours Director 111-50-1649 1___M 2**X** F Yrs York Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d Inside City Limits or 28a-f show 1 Yes 2 No "natural", or items 23a or 28a-f sho Harford Street death with the Maryland Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1532 Clearview Drive United States Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc 1 Never Married 2 Married Yes more, MD 21215-0036
Pages I and 2 should be filed within 72 hours after near of Health and Mental Hygiene. White 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify: <u>۾</u> Dates 16a, Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Housewife Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ralph Gloria Burgess Griffin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ို 19a. Informant's Name/Relationship (Type, Print) Itimore, MD other traumat 4208 Madonna Road Stephanie L. Weber (Dau. Jarrettsville, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Aug. 1 Burial 2 Cremation 3 Removal from State crematory or other place) Baltimo
permit. Page.
Department o
Important: injury or oth 2010 Carroll Cremation Other Specify: Hampstead. 4 Donation 5 22. Name and Address of Facility E.G. Kurtz & Son Funeral Jarrettsville, Maryland Home Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hea **Physician** failure. List only one cause on each line Between Onset and Medical Death a Multiple Sharp Force Injuries Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the bunal - transit Physician/Medical UNPENDED AMENDED Box 68760, IF FEMALE 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy 1 Live birth Day Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 V Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Þ 1 Yes 2 V No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed death? Yes 2 No 1 🗸 Yes ospital or Attending Physician: hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene 1 Yes 2 No 28a. Date of Injury (Month, Day,Year) FOUND: 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: Subject stabbed and cut Natural FOUND: 1 Yes 2 V No Director: Pending Aug 7, 2010 2125 hrs Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 1532 Clearview Drive, Street, MD To the Hospital o within 24 hours af To the Funeral D (Specify) Mobile Home 4 V Homicide 29a. Certifier 1 completely Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

Registrar

Medical

one)

Russell Alexander MD

29b. Signature and title of certifie

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Registrar's signatur

and manner stated

30. Name and address of person who completed cause of death (Item 23a)

29d. Date signed (Month, Day, Year)

August 8, 2010

2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DOUGLAS BARROW PAUL Month 0755AM 2010 ugust Medical 4a. Facility Name (if not institution, give street and number)
WASHIGTON COUNTY HOSPITAL **Examiner** 4b. City, Town, or Location of Death 4c. County of Death
WASHINGTON HAGERSTOWN 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 6 (1/2011), 1/21/9/240 Birthplace (State or Foreign Country) W V **Funeral** 232-26-5133 1 🕅 M 2 🗆 F Days Hours Min. 90 Director Yrs Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director BERKELEY INWOOD W۷ 1 Yes 2 No 10e. Street and Number ŏ 10f. Zip Code 10a. Citizen of What Country? Funeral items 23a 547 McDONALD DR 25428 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Ⅸ Yes 2 ☐ No If Yes, Give Year or Dates, 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ö ģ 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 'natural", 1 ☐ Yes 2 💢 No Specify: WHITE Specify: Completed 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
HOUSEKEEPING 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) VETERANS HOSPITAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve once. ဂ STANLEY BARROW SUSIE McFILLAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 547 McDONALD DR., INWOOD WV 25428 ANN L. SORRELLS / DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State PLEASANT VIEW MEM GARDENS 8/11/2010 MARTINSBURG, WV 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility BROW FUNERAL HOME, P.O. BOX 821, 327 W. KING ST., MARTINSBURG, W 25402 clut 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Schen Priysician/ MYOCAM disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner NOWI sequentially lies conditions; if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): the burial-transif 5-650 enal that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 as t IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year the 9 Unknown 9 Unknown To the Hospital or Attending Physician: The law requires that the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has page performed? 2 🗌 No Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No after death.

Director: After this certific d in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural injury 5 Pending Accident
Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 5 6 6 0 3 9 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar MURSHED

32. Registrar's Signature

FARIO
31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra MEND#5perFH, 8/3/10, EMW, McCo Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 16^{pay}2010^{ear} Physician/ July Elmer Blue 1945 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery 502450 will (Umble 620 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** 1 ፟፟ M 2 □ F Country) C 1^{M2}1th 1³ / 1⁹ 925 84 Director Usual Residence of Decedent ıral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County with the Maryland Director MD Montgomery Silver Spring 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 130 Woodridge Avenue 20901 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: "natural", If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Banker Madison Nat'l Bank Be 18. Mother's Name (First, Middle, Maiden Surname) filed 17. Father's Name (First, Middle, Last) ပ M.N.Blue Carrie Walker should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $~2\,0\,8\,1\,4$ permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Thomas Donohue/Attorney 7101 Wisconsin Ave Suite 1114 Bethesda, Md. Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Cross Creek Cem. 8/01/2010 Fayetteville, N.C. В ☐ Other (Specify) 4 Donation Signature o eral Service Dice PATETY ADERINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring.Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Respiratory failure disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Community acquired pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): and that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be exect within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician any completed filled in by the funeral director, page 2 should be detached for use as the burial-tra Due to (or as a consequence of) resulting in death) Last Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> septic shock, atrial fibrillation Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performe 1 ☐ Yes 2 🛛 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 🕱 No ပ္ 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 Yes 2 No 1 X Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 | only one) 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year)

12

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

2. Registrar's Signature

MID

Name and address of person who completed cause of death (Item 23a) (Type, Print)
Bhikkaji Smitha MD 1500 Forest Glen Rd.Silver Spring, Md 20910

and

D0064100

July 17,2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 25624 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Jacqueline Bean Ann p^Mq July 2010 48 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson Gilchrist Hospice 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🗙 F Months Hours Min. 4/7/1969 **Director** 41 214-08-2766 MD Usual Residence of Decedent 28a-f show 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits Directo Carroll Reisterstown MD. 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21136 USA 3500 Dumphries Drive 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ۾ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: white Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) systems administrator 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard Atkins Linda Pugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sh ment of Health a tant: If item 27 is Mark O. Bean, husband 3500 Dumphries Drive, Reisterstown, Md. 21136 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Page 1 a Department of H Important: If ite any injury or ot 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) John's Leisters 7/30/2010 Westminster, MD. 21. Signature of Funeral Service Licensee M00741 22. Name and Address of Facility Eline Funeral Home L Lemmer 934 S. Main St., Hampstead, Md. 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. immediate Cause (Final Onset and Death Physician/ METASTATIC Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin sician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death as been signed by the 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy page 1 Yes 2 No 2 N Be Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No မ 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 5 Pending s after death. I Director: Aff d in by the fu 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 8 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours a Medical 29a. Certifier 1 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and title of certifie WIL 00070635 MD

State

Box 68760

Records,

Division of Vital

Registrar

DHMH 17 Rev 7/2009

Charles

Baltimore, MD

N

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701

Pate

aura 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death HRISTINF Physician/ 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washington Washington County Hospital Hagerstown 9. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Min. 1 M 2 F Months Hours M7471932 237-40-1320 78 **Director** Usual Residence of Decedent show Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland **Funeral Director** Washington MDHagerstown 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 30 Richmond St. Apt. 21740 **USA** 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 □ Divorced White Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Frank Orr Mary Lee Hilliard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) D. Kay Collier (Daughter) 4621 North Ave. #7, San Diego, CA 92116 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation √3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Smithsburg Crematory 8/4/2010 Smithsburg, MD 4 Donation 5 Other (Specify) . Signature of Fundral A rvice Name and Address of Facility erald N. Minnich Funeral Home 805 N. Potomac St., Hagerstown 101 21740 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/) Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to minisorate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Pregnant at time of death Yes 2 No Unknown 9 Unknown been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown To the Hospital or Attending Physician: The law require within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne eath 28b. Time of Certificate: 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending work? 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29b. Signature and title of certific 00065024 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IQUE a SH-10 31. Date filed (Mont) State Registrar

DHMH 17 Fey 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1 - State Registrar C6	ertificate of Death	Il Hygien 2010 25626 Reg. No. e of Death 3. Time of Death
Physician /Medical	1. Decedent's Name (First, Middle, Last) Mary Katherine CARR 4a. Facility Name (If not institution, give street and number)	Moi	
Examiner Funeral Director	$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$		Washington e of Birth nnth, Day, Year) Pee 17 1919 Washington 9. Birthplace (State or Foreign Country) Maryland
be filed within 72 hours after death with the Maryland tala Hygiene. d other than "natural", or items 23a or 28a-f show event, it a fredical Examination must be notified at Be Completed by Funeral Director	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	stown 10f. Zip Code 21740 Was Decedent of Hispanic Origin? (Specify Ye If Yes, specify Cuban, Mexican, Puerto Rican, or I Yes 2 No Specify: edent's Usual Occupation	10d. Inside City Limits 1
	Elementary/Secondary (0-12) College (1-40r 5+)	e kind of work done during most of working DO NOT use retired) memaker 18. Mother's Name (First, Alyce Valent	Her own home Middle, Maiden Surname) tine
and Health Im 27 Her tr	19a. Informant's Name/Relationship (Type. Print) Sandy Swain - Daughter 370	ling Address (Street and Number or Rural Route) Martina Drive, Chamb ob Date permatory or other place)	
permit. Pages 1 Department of I Important: If ite any injury or ot once.	1 K Burial 2 Cremation 3 Hemoval from State 4 Donation 5 Other (Specify)	ren Cemetery 8/7/10	Hagerstown, Maryland innich Funeral Home agerstown, Md. 21740
ate be executed which and he burial-transit he be executed with the burial-transit he be executed with the burial-transit he be executed with the burial-transit he burial-tra	23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	- w	Onset and Death
nat the death certificate by the attending physic letached for use as the by Physician/Medica		B ☐ Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
w requires that the disben signed by the should be detached leted by Physic	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	3e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 ☑ No 3 □ Probably 4 □ Unknown
The law requii icate has been s page 2 should	Diabetes Mellitus	11	4a. Was an autopsy performed? ☐ Yes 2 ☐ 1 ☐ Yes 2 ☐ No
To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. Within 24 hours after death. To prefer the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the Medical Certification: To Be Completed by Physician/Medi	25. Was case referred to medical examiner? 1	of 28c. Injury at 28d. D	ck only one) Residence 6 Other (Specify) Place escribe how injury occurred escribe (Street and Number or Rural Route Number, sty or Town, State)
o the Hospita ithin 24 hours o the Funeral ompletely filled	29a. Certifier (Check only one) 1 ✓ Certifying Physician: To the best of my knowledge, de 2 ☐ Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurred at t	the time, date and place, and due to the cause(s)
wit O	29b. Signature and title of certifier Cypthus Kuther-Sands, MC 30. Name and address of person who completed cause of death (Item 23a) (Typ	29c. License number D47451 e, Print)	29d. Date signed (Month, Day, Year) August 4,2010 747 Northern Avenue Hagers town, Mary Land 2174
H-3 State	Cynthia Kuttner-Sanas no Hospici 31. Date filed (Month, Day, Year) 32. Registrar's Signature	or Washington County,	Hagers town, Mary land 2174

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State Registrar		arylanc	Cer	tificate of L	Death	and we	эпаг пу	Reg. No	2010	25627
Physi Me	ician edica		Decedent's Name (First, Middle, La DANA	ast) GERARD	CABL	E				2. Date of De _Month JULY	ath Da	ay Year 2010	3. Time of Death 12:32 A M
Exar			4a. Facility Name (if not institution, giv $Frederick\ M$		anita'	1	4b. City, Town, or Frede		of Death	-		County of De	ath
Fune Direct			5. Social Security Number 6.		66 66		If Under 1 Year Months Days		Min.	3. Date of Birl (Month, Da ug • 27	th	9. B	irthplace (State or Foreign ountry)
		إ	Usual Residence of Decedent 10a, State 10b. County			Town or Loc	eation		J JA	ug. 2/	, 1	943 Pe	nnsylvania 10d. Inside City Limits
Marylar 28a-f st otified		Director	Maryland Frede	rick		lerick							1 ☐ Yes 2 ^X No
vith the 23a or st be n	-	ia D	10e. Street and Number 8605 Pinecliff D	wi		-	10f. Zip Code	170%				tizen of What C	
death v r items iner mu	ı.	- 1	11. Marital Status	12. Was Decedent E Armed Forces?		13. V	Vas Decedent of Hi Yes, specify Cuba	1704 ispanic Or in, Mexica	igin? (Specif n, Puerto Rid	fy Yes or No- can, etc.)		nited S 14. Race - Am Black, Wh	erican Indian,
5-UU30 2 hours after "natural", or		lea by	1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣 I If Yes, Give Year or Dates.	No	1	☐ Yes 2基 No	Specify	:			Specific	hite
ZID-L	1	Completed	15. Decedent's (Specify only highest g			(Give k	ent's Usual Occupa ind of work done of NOT use retired)	ation during mos	st of working		16b. K	ind of Business	s Industry
d Z L L		n F	17. Father's Name (First, Middle, Last)	5+	+)		Profess			First, Middle,		Hood Co	11ege
yland Id be filed Mental Hy larked ott		2	Boyd Cable						n Clov		iviaideri	Surname)	<u>.</u>
Datiumore, Interviend Z I Z I 3-0030 permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at			19a. Informant's Name/Relationship (Jenny Morgan/ Day	,, ,			g Address (Street a Valley V						
IOFE, ge 1 and nt of Hea If item or other		Ī	20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 [Removal from State		ce of Dispos	sition (Name of natory or other plac		Dat			ocation - City o	
Dartimor Dermit. Page 1 Department of mportant: If it any injury or or	ouce.	ŀ	4 ☐ Donation 5 ☐ Other (Special Signature of F and Service Lices		Mt.	01ive	t Cemete:	ry ss of Facili	8/5/2	010	Fre	ederick	, Maryland
	8	4	23a. Part 1. Enter the disease, or con	2//kgun	the death	IS 16	21 Opossi	unera umtov	vn Pik	es P. e, Fre	A. deri	ick,Mar	yland 21702
Enysicia	nz i		shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line.				y, such as	cardiac or n	espiratory an	est,		Approximate Interval Between Onset and Death
Medic Examin	_		resulting in death)			nce of):	hode						Days
sit sd	Evaminor		Sequentially list conditions, if any, leading to immediate	b. Due to (or as a									
cate be executed physician and the burial-transit	2	LYG	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a	conseque	nce of):							
icate be executed physician and sthe burial-transi	150			■ d									
	levipo/Modicial		F FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	2 🔲 Fetal o	death 3 🗌	Ectopic pregnanc	y			-	23d. Date of do	elivery Day Year
that the degree by the good detached is	Dhyci	-	1 Yes 2 No 9 Unknown	4 ☐ Pregnant at 9 ☐ Unknown			Other (specify)						
(A E S	3	בי ב	Part II. Other significant conditions	contributing to death bu	it not result	ting in the ur	iderlying cause giv	en in Part	I. 			,	o the cause of death? Probably 4 D Unknown
The law require cate has been signage 2 should b	Completed									24a. Was a		24b. Were a prior to death?	utopsy findings available completion of cause of
sician: The certificate I rector, page	Pa C	- 1	25. Was case referred to medical examiner?				26. Pla	ace of Dea	ith <i>(Check or</i>	1 Tyes			es 2 🗆 No
Physician: 1 Physician: 1 r this certifica	2	2	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 Anpatie 28a. Date of injur		R/Outpatient	: 3 DOA Othe	4 ⊔ N		5 Resid		Other (Spe	cify)
tending leath. tor: After the funer	Cortificato.		1 Natural 5 ☐ Pending 2 ☐ Accident Investigatic 3 ☐ Sulcide 6 ☐ Could not l	he		injury	M 1 🗆	? Yes 2 □		a. Describe in	Ow injury	y occurred	
al or Att			4 Homicide determined			e, farm, stre	et, factory, office		281	f. Location (S City or Tow			ural Route Number,
To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completed filled in by the funeral	Medical		(Check 2 Medical Exam	ysician: To the best of n niner: On the basis of ex rse Practioner: To the b	amination a	ind/or investi	gation, in my opinio	n, death o	ccurred at the	e time, date a	nd place,	, and due to the	cause(s) and manner stated.
To the comp	-		29b. Signature and title of certifier		,		29c. License	number				te signed (Moni	th, Day, Year)
		3	30. Name and address of person who	completed cause of de	ath (Item 2	3a) (Type, Pr	int)	5161	C			1/30/10	3
_5	tate	3	1475 Towey B1. Date filed (Month, Day, Year)	Aue F	rele	sick,	garkel	217	02	-			
Regis			AUG 2	2010 Den	sind o	13. 1	gare						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Francis Colantuno Joseph 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County_Hospital Ha∘erstown Washington Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 1 ፟ M 2 ☐ 9. Birthplace (State or Foreign **Funeral** Hours June 22, Year) 177-30-6390 Director 70 Pennsylvania Usual Residence of Decedent 10a. State 10c. City, Town or Location be notified at 10d. Inside City Limits Director Tioga 28a-i Westfield 1 🗌 Yes 2 ី No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 193 Harvey Avenue 16959 U.S.A 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 1962 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or ite þ 1 Never Married 2 Married ^{2 □} № 1962-Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 X Divorced 1968 White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) City Government Director of Health and Mental Hygi item 27 is marked other other traumatic event, it Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Francis Joseph Colantuno Marie Castagliuolo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Colantumo / Son 8110 Mapleville Road Roonsboro. Maryland Date unk 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Important: If it any injury or c cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Arlington Natl. Cem. 22. Name and Address of Facility Bast-Stauffer Funeral Home. PA 21. Signature of Funeral Se 760<u>6 Old National Pike</u> Boonsboro. MD 23a. Part 1.7 nter the disease, or complications that, aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Physician/ vin. Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): 5 m/ as the burial-transi Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 🗌 Yes 2 🗌 No 3 🔲 Probably 4 🖵 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an • Hospital or Attending Physician. The law 24 hours after death.
• Funeral Director. After this certificate has leaded. performed' 2 🗌 No Yes 2 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: ျ 1 🗌 Yes 2 1Vo 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Matural 5 Pending work? Accident 2 🗌 No Investigation completed filled in by the 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 29b. Signature and title of certifier 0060396 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 41-5+1 MUNSHIP 31. Date filed (Month 32. gistrar's Signature State

DHMH 17 Rev 7/2009

Registrar

P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 25629 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ Month JULIE CHIAPPETTA 010 5:00 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK 5. Social Security Number 6. Sex 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York 7. Age (In vrs. last birthday) If Under 8. Date of Birth **Funeral** 1 □ M 2 🕱 F Months Days July 22, 1957 Hours 218-72-8283 53 Director Usual Residence of Decedent ıral", or items 23a or 28a-f show Examiner must be notified at filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Washington Cascade 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 25340 Cherry Lane 21719 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. 3 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XX No Specify. White "natural", Specify: 3 ☐ Widowed 4 X Divorced Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Customer Service Manager Mortgage Lender Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Amedeo Chiappetta Amelia Saranatti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John J. Shorb, Jr. / Partner 25340 Cherry Lane, Cascade, MD 21719 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place, Resthaven Crematory 2010 Frederick, Maryland 21. Signature of Fineral Sanice Licenses Restnaven Funeral Services, Skkot Cody P.A. Frederick, MD 21701 9501 Catoctin Mountain Hwy. 23a. Par 4. Enter the disease or co shock, or heart failure. List only cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on each line. Interval Between Onset and eath Immediate Cause (Final Physician/ disease or condition econds Medical resulting in death) Due to (or as a consequence Examiner minutes Securations list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical days Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Unknown 1 Yes 2 2 9 Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown been s 24b. Were autopsy findings available prior to completion of cause of has autopsy performed death? eral Director: After this certificate I filled in by the funeral director, page 2 1 No 1 Tyes Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 유 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mann f Death 28a. Date of Injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: At completed filled in by the fu 1 🗌 Yes 2 No ☐ Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in magnific Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe 29d, Date signed (Month, Day, Year) MD

Registrar
DHMH 17 Rev 7/2009

State

Yun

32. Registrar's Signature

30. Name and address of person who completed eause of death (Item 23a) (Type, Print)

28

JUL

31. Date filed (Month, Day, Year,

MDD 67442

arks

Thomas Johnson Drive,

2010

			1 - For State Registrar		Marylan		artment of F rtificate of			R	eg. No2 (010	25630
	Physicia /Medio		1. Decedent's Name <i>(First, Middle, La</i> Marshal Chast							Date of Deat Month gust	Day	2010	3. Time of Death 08:43 AM
de	Examin		4a. Facility Name (If not institution, gi				4b. City, Town, o		of Death			nty of Death	
- 1			Union Hospital of Social Security Number 6.5		County 7. Age (In yrs. I	in në faluëh da ci	E1kt		24 Hrs I o	Date of Birth		Cecil	place (State or Foreign
	Funeral Director		423-18 - 9048	1 X M 2□F	7. Age (III yrs. I	Yrs.	Months Days	Hours	Min	Month, Day	Year)	Alaba	place (State or Foreign Styrmingham Ima
	ō		Usual Residence of Decedent										
	arylar show	-	10a. State 10b. County		10c. City	y, Town or Lo	cation						0d. Inside City Limits 1 □Yes ※ No
	he Ma	Directo	Maryland Cecil			E1ktc	10f. Zip Code				0g. Citizen o	of What Cou	Λ
	with yard		212 Whitehall Ro	nad.			219	21		'		ted St	•
	172 hours after death with the Maryland "natural", or items 23a or 28a-f show ideal Evantine Frust be notified at	Funeral	11. Marital Status	12. Was Dece	dent Ever in U.S	S. 13.	Was Decedent of H		igin? (Specify	Yes or No-	14. R	lace - Ameri	can Indian,
õ	after or ite		1 ☐ Never Married 2XXMarried	Armed For 1XXes If Yes, Giv	2 □ No		niyes, specily Cuba 1 ∐ Yes 2 XX √lo	Specify:		ari, etc.)	Spec	lack, White,	eic. nite
2-003p	ural",	d by	3 Widowed 4 Divorced	Year or Da	tes:1943 <u>y</u>	45						,	
ņ	n 72 l	Completed	15. Decedent's E (Specify only highest gr	ade completed)		(Give	dent's Usual Occup kind of work done DO NOT use retired	durina mos	t of working		16b. Kind of	Business/in	dustry
7 7	l within giene. r than "	mo	Elementary/Secondary (0-12)	College (1-	-4or 5+)		trician	-,			Autom	otive	
and	be filed ttal Hygi d other event, I	Be C	17. Father's Name (First, Middle, Las	")				18. Mothe	er's Name <i>(F.</i>	irst, Middle, i	Maiden Surn	ame)	
) Na		2	Emmit Chastain					Rho	oda No	rris			
Mar	s 1 and 2 should if Health and Mer Item 27 Is marke other traumatic		19a. Informant's Name/Relationship	(Type. Print)		19b. Maili	ng Address (Street	and Numbe	er or Rural R	oute Numbe	r, City or Tou	vn, State, Zi	o Code)
a)	s 1 and 2 of Health Item 27 I		Marshal Chastain	_Jr/_	Son 20b. P	2046	Hurond D	rive,	Aiken Date	South	Caro	1ina 2 n - City or To	29803 own. State
101	Pages nent of int; if its iry or o		1XBurial 2 ☐ Cremation 3	Removal from S			sition (Name of matory or other place t United		August	9,	Jorth '	Fact	Maryland
altimor	# 문문을 .		4 Donation 5 Other (Oyeca 21. Signature 4 Service 5	ee	Met	hodist	Cemeter 2. Name and Addri	ss of Facilit	Crouc	h Fune	eral H	ome	nary rana
Ď	Depared Important any Ir	0 9	1.000	1									yland21901
			23a. Part1. Enter the disease, or con shock, or heart failure. List only			. Do not en	ter the mode of dyi	ng, such as	cardiac or re	espiratory arr	est,		Approximate Interval Between
100	Physician		Immediate Cause (Final disease or condition	. C	010	Exa	cerbat	100					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):		1 2/12					1.000 -
	Laminei	je i	Sequentially list conditions,	b. Don't f	neun	nonig						_	1 W CER
_	uted J unsit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	200 100 4		2.2.2.121							
'n	exec an and rial-tra	Exa	resulting in death) Last	Due to (or as a consequ	uence of):							
0/00	cate be executed oblysician and the burial-transit	dical		d									
0	ertifica ling pl	Med	IF FEMALE:										
Ž D D	ath cattend	Physician/Med	23b. Was decedent pregnant in the past 12 months?		irth 2 🗆 Fetal	death 3	Ectopic pregnand	су				Date of deliv Month	ery Day Year
5	the de	ysic	1 □Yes 2 □No 9 □ Unknown	9 Unkno	ant at time of down	leath 5L	Other (specify)						
	that the		Part II. Other significant conditions	contributing to de	ath but not resu	ulting in the u	nderlying cause giv	en in Part I	. #	23e. Did to	bacco use co	ontribute to	he cause of death?
vital necords	quires an sign uld be	ed by	Coronary	Artery	Disea	80				1 🗆 Y	es 2 🗆 No	3 ☐ Pro	bably 4 Unknown
ວ	aw re as bee 2 sho	Completed	Diabetes	Mell	Em 7	gre a	2_			24a. Was a		b. Were aut	opsy findings available ompletion of cause of
ב ב	The late ha	E O				//				autop: perfor 1 □ Yes		death?	2 No
<u> </u>	clan: ertific ictor,	Be (25. Was case referred to medical examiner?						e of Death (C				
5	hysic this or al dire	은	1 Yes 2 No				nt 3 DOA Oth	7 🗆 140	ursing Home				f(y)
	Jing F	ion:	27. Manner of Death 1 Natural 5 Pending		h, Day, Year)	28b. Time o Injury	Wor	ryat k?]Yes 2. □		I. Describe h	ow injury occ	curred	
ISIOII	Attend death ctor: y the	ficat	2 Accident investigation 3 Suicide 6 Could not to	e 280 Place	of Injury - At ho	me, farm, sti	eet, factory, office	1162 2		Location (S	treet and Nu	mber or Rui	al Route Number,
<u>}</u>	after after Directory	Certification:	4 Homicide determined	buildir	ng, etc. (Specif)	v)	,,,			City or Tow	n, State)	771007 07 7107	a. 110010 1101111 01,
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. Within 24 hours after death. To thin Funeral Director. After this certificate has been signed by the attending picompletely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the complete of the funeral director.						h occurred at the ti						
	the Hv iin 24 the Ft	Medical	one)	and manr		non and/or if	vestigation, in my		atri occurred				
	With Con	Σ	29b. Signature and title of pertifier		lia.		29c. Licens	se number	00	1	29d. Date sig	ned (Month	Day, Year)
				2-peza			U U	0 1 1	02 5t.		01	>/10	
8	TIVA		30. Name and address of person who	completed cause	e of death (Item	1 23a) (Type,	Print) Cath	edral	St.	EIKH	n mo	2(9	121
	Sta	te	31. Date filed (Month, Day, Year)		egistrar's Signa								
			AUC 0 4 2010	A N	-		"						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar	tate of Maryland	Certifica			ivientai Hy	/giene Reg. No 2	010	25631
	Physicia Medic		1. Decedent's Name (First, Middle, Last) RUTH	MELDA	COUGHLI	N		2. Date of D Month JULY			3. Time of Death
*	Examin	er	4a. Facility Name <i>(if not institution, give</i> street FREDERICK MEN	ORIAL HOSPIT	CAL :	FREDEI			4c. Cou	nty of Death REDER	
	Funeral Director		5. Social Security Number 579-48-4351 6. Sex	7. Age (In yrs. las 86	Yrs. If Un Month	der 1 Year s Days	If Under 24 Hrs. Hours Min.	(Month, D	irth a <i>y</i> , Yea <i>r)</i> 3 / 1 9 2 4	Cou	nplace (State or Foreign ntry) D A
	laryland 8a-f show ified at		Usual Residence of Decedent 10a. State MD 10b. County Frederi	ck 10c. City,	Town or Location Freder	ick					10d. Inside City Limits
	with the N 23a or 28 ust be not	Funeral Director	10e. Street and Number 100 Burgess Hill	Way Apt.		Zip Code 21	702		10g. Citizen	of What Cou	intry?
9036	je 1 and 2 should be filed within 72 hours after death with the Maryland t of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	ρ	1 Never Married 2 Married	Vas Decedent Ever in U.S. urmed Forces? Yes 2XXNo Yes, Give Year or Dates.		edent of Hi becify Cubar 2 XNo	spanic Origin? (Sp n, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	- 14. F E Spec	Race - Ameri Black, White, city: Wh	
Maryland 21215-0036	within 72 hou giene. ner than "natu ner the Medica"	Completed	15. Decedent's Educati (Specify only highest grade co		16a. Decedent's Ui (Give kind of v life. DO NOT u opera	vork done d ise retired)	ation luring most of wor	king		f Business Ir 1epho	one co.
yland	should be filed h and Mental Hy 7 is marked oth traumatic event	To Be	17. Father's Name (First, Middle, Last) Leslie R. Lewis	Sr.			18. Mother's Nar Ge	ne (First, Middle rtrude	, Maiden Surna Ashe	ime)	
, Mar	ind 2 shou lealth and im 27 is m		19a. Informant's Name/Relationship (Type, P Laurence King (G	randson)		onega	ate Dr.	, Fred	lerick	, MD	21702
Baltimore,	permit. Page 1 a Department of I- Important: If ite any injury or ot		20a. Method of Disposition 1 □ Butial 2▼ Cremation 3 □ Rem 4 □ Donation 5 □ Othe (Specify)	oval from State 20b. Pla cer Smi	nce of Disposition (N metery, crematory o . thsburg					hsbur	g, MD
Bal	permit Depar Impor any in		21. Signature of Europa Service Libensee	\leq	I POB	<u> 18, 1</u>	· Thomp Middlet	own, N	<u>ID 217</u>	Home	<u>;</u>
	Physician/ Medical		23a. Part 1. Enter the disease, or complications, or heart failure. List only one call immediate cause (Final disease or condition resulting in death)	ise on each line.	aboli			•	,	ic)	Approximate Interval Between Onset and Death
	Examiner	ner	Sequentially list conditions, b. — translated cause. Enter Underlying	Litype	s tems	00	A		1.00		
0	cate be executed physician and s the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or irinjury that initiated events resulting in death) Last	Due to (or as a conseque		<u>,</u> d	liff	col	: +, S	\dashv	
P.O. Box 68760	ath certific attending for use as	Σ	in the past 12 months?	i yes, outcome of pregnanc Live Birth 2 Fetal or Pregnant at time of de Unknown	death 3 🗌 Ectopi		у			Date of delive	very Day Year
ds, P.O.	requires that the de been signed by the should be detached	by	Part II. Other significant conditions contribu	iting to death but not resul	ting in the underlyin	g cause giv	en in Part I.				the cause of death?
Division of Vital Records,	r: The law red icate has be r, page 2 sho	Completed	25. Was case referred to medical					perl 1 Yes	s an 24 opsy ormed? 2 No	prior to co death?	opsy findings available ompletion of cause of
Vita	ysiciar is certif directo	To Be	examiner? 1 Yes 2 No	tal: 1 Inpatient 2 E	R/Outpatient 3 ☐		ace of Death <i>(Che</i> er: 4 Nursing F	ck only one) Iome 5 ☐ Res	idence 6 \square C	Other (Specif	
ion of	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2:		Natural 5 Pending 2 Accident Investigation	8a. Date of injury (Month, Day, Year)	8b. Time of injury M	28c. Injury work' 1 🔲			how injury occ		
Divis	pital or Al burs after or sral Direct		4 Homicide determined	Be. Place of Injury - At hom building, etc. (Specify)			dete conductor	City or To	wn, State)		al Route Number,
	To the Hospital within 24 hours or the Funeral Completed filled	Medical	29a. Certifier (Check only one) 29b. Signature and title of certifier	In the basis of examination a ctioner: To the best of my k	and/or investigation, knowledge, death oc	in my opinio	n, death occurred e time, date and pla	at the time, date	and place, and	due to the ca manner as s	ause(s) and manner stat stated.
	F > F &		1 my 12	e Nam			35106		4		20/0

State Registrar Myung Hee Nam
31. Date filed (Month, Day, Year)
JUL 29 20 0 32. R

400

32. Registrar's Signature

Frederick, MD 21701

10-05534	Please Type	or Print in Blac e of Maryland / D	k Indelible	e Ink. I	Ensure All (Copies Are L	egibl	e., , ,	0 05000
Joan Elizabeth Cor	ndyles Stat	-	-			ntal Hygiene		201	0 25632
	1- For State Registrar		Certificate	of Dea	nth		Reg. No		
Physician/		ast)				2. Date of D Month	eath Day	Year	3. Time of Death
Medical Examine	O Carr Erradocerr					July 24,	2010		1150 hrs
	4a. Facility Name (if not institution,			1	, Town, or Location	of Death		c. County of D	
	NB Route 113 at Beth E				omoke			Worcester	
Funeral			yrs, last birthday	y) If Un Mon		ler 24Hrs. 8. Date of		l c	oroign
Director	215-62-0481	\square M 2 \mathbb{X} F $\boxed{54}$		Yrs.	and Days Hour	s Min. 6 19	1956)	Country) Delaware
>	Usual Residence of Decedent 10a, State 10b, County	Iao	City, Town or L	tion					10d. Inside City Limits
w an	· ·		•						1 X Yes 2 No
Varyland 28a-f show any 1 at once. ector	Maryland Worcest	er Po	ocomoke				140: 00	C C > A ff 4	
the Marylanc a or 28a-f sh tifted at once	10e. Street and Number				ip Code		l i	tizen of What	Country?
h the	106 Adkins Place				851	<u> </u>		JSA	
er death with , or items 23. r must be not Funeral	11. Marital Status 1 Never Married 2 X Marr	12. Was Decedent Ever	r in U.S. 13			igin? (Specify Yes or n, Puerto Rican, etc.)	No-	14. Race - A White, e	merican Indian, Black, tc.
or it	To rever warred 2 22 warr	1 Yes 2 X	No					Tu	The district
s afte	3 Widowed 4 Bivor	ed If Yes, Give Year or Dates:	1		2 No specify al Occupation (Give		1ch	Specify: W Kind of Busin	
hour Exar	Elementary/Secondary (0-12)	College (1-4 or 5+)			orking life. DO NOT				r County
36 Jin 72 Shan dical	Lienteritary/occordary (0-12)		Phyai	രാ 1 ന	herapist		Во	ard of	Education
21215-0036 uld be filed within 72 hour Mental Hygiene. marked other than "natu e event, the Medical Exan To Be Completed	12 17. Father's Name (First, Middle, La	4	Filiysi	.cai i		r's Name (First, Middle	e, Maider	n Surname)	
215 be file ontal Hy rrked o ent, th		,				oie Furia			
212 ould b d Ment s mark fic eve	19a. Informant's Name/Relationship	(Type, Print)	19b. M	ailing Addre		mber or Rural Route N	lumber, C	City or Town, S	State, Zip Code)
MD id 2 sho lith and in 27 is sumati	Joe Condyles Hus	band	106	Adkir	ns Pace, 1	Pocomoke C	ity,	MD 21	851
	20a. Method of Disposition				ame of cemetery,	Date	20c.	Location - Cit	ty or Town, State
10r ages nt of tt: If other	1 X Burial 2 Cremation	3 Removal from State	First	ptist	e)Church	7 31 2010	Do	ocomoke	e City, MD
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite	4 Donation 5 Other Spec 21. Signature of Funeral Service Lic	ensee	Cemetery		d Address of Facilit			COMORC	. CICIT IID
Balt permit. Depart Import injury	Heall M. L.	ines CF56	′	501 S	way runer now Hill	al Home P Rd.,Salisk	.A. ourv	, MD 21	.804
Physician	23a. Part I. Enter the disease, or co		death. Do not en						Approximate Interval
/Medical	failure. List only one cause or Immediate Cause (Final disease	a, Multiple Injuries							Between Onset and Death
Examiner	or condition resulting in death)	Due to (or as a conseque	nce of):						
	Sequentially list conditions,	b							
in a line	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conseque	nce of):						
ted Insit Examine	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	nce of):						
uted nd ransit	ovomo josami g in count, cue	d.							
executed ian and ial - transi		AMENDED							
). Box 68760, the death certificate be ey the attending physicia clothed for use as the burial Physician/Media	IF FEMALE:	23c. If yes, outcome of	f pregnancy				23	3d. Date of del	livery
Box 68760, e death certificate be the attending physic ed for use as the but hysician/Med	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2	Fetal deat	h 3 Ectopi	ic pregnancy		Month	Day Year
or use	1 Yes 2 No 9 ✔ Unkno	4 Pregnant at time	of death 5	Other (Sp	ecify)				
B. B. Be de he de fine de fine hed fi	Bort II Other significant condition	19 UNKNOWN	not regulting in	the underlyin	a cauca civan in P	art I 23a Die	d tobacco	use contribut	te to the cause of death?
cords, P.O. Box 68760, law requires that the death certificate be executed has been signed by the attending physician and 2 should be detached for use as the burial - transition between the burial - transition by Physician/Medical Ex		s contributing to death out	. not resulting in	ine underlyii	ig cause given in F		_		Probably 4 Unknown
S, F luires Id be	ļ 								re autopsy findings available
Cord law req has bee		<u>-</u>				au	topsy	prio	r to completion of cause of
Records, The law requires ficate has been sig page 2 should be Completed							rformed? s 2 1		th? Yes 2 No
Vital Recysician: The label corridicate la director, page	25. Was case referred to medical				26 Place of Death	(Check only one)			
f Vita Physici or this or ral direc	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpa	tient 3	DOA Other	Nursing Home 5	Reside	ence 6 🗸 (Other: Scene
n of ing Pt After I tuneral	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time		28c. Injury at Worl			jury occurred	another vehicle who
icendi eath.	1 Natural 5 Pending 2 Accident Investig		1129 hrs	5	1 Yes 2 🗸	No failed to s		Struck by	another verticle with
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach ertification: To Be Completed by P	3 Suicide 6 Could r	28e Place of Injury	- At home, farm,	street, facto	ry, office building, e	etc. 28f. Location or Town		and Number o	or Rural Route Number, City
Division o Hospital or Attending 24 hours after death. Funeral Director: Aftered filled in by the funeral filled in by the funeral Certification:	4 Homicide determi		Road / Highv	way		NB Route 1	13 at Be	eth Eden Ch	urch Road, Pocomoke, M
		ician: To the best of my kno							
To the Ho within 24 To the Pu completel	one) 2 Medical Exami	ner:On the basis of examina and manner stated.	tion and/or inves	_					
>-0 💆	20h Signature and title of certifier			1 2	9c. License number		1 204	Date signed	(Month Day Year)

30. Name and address of person who completed cause of death (flem 23a) Zabiullah Ali, M.D. Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year) State Registrar

July 25, 2010

O.C.M.E.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Amend#31 PerVRPGC8-4-10cr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ju1yKatherine Patricia Dixon 4:10 AMM 26 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 7805 Rhonda Lane Clinton Prince Georges 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 06/30/1946 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** DC Country) Hours 1 □ M 2 🛛 F 64 577-66-0569 Director Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director DC Washington 1 🛂 Yes 2 🗌 No 9 10e, Street and Number 10f, Zip Code 10g. Citizen of What Country? items 23a Funeral 20018 USA 1840 Michigan Ave death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 Married Maryland 21215-0036 hours after 1 ☐ Yes 2 ₺ No Specify: Specify: Black Completed 3 Widowed 4 X Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene. Dr. Adclph Johnson Elementary/Seconday (0-12) College (1-4 or 5+) **Cental Assistant** 12th DDS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hupert Johnson permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. Francenia Burgess 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronnie Dixon/ Son 14705 Bisque Street Accokeek MD 20607 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 07/31/2010 Washington, DC Olivet Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Washington,DC20019 Dunn&Sons Funeral Home 5635 Eads St.NE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onser and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Dus to (or as a consequence of) If any, leading to himediate cause. Enter Underlying Exami Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death ed by the a 9 Unknown 9 Unknown P.O. s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires 124 hours after death. Funeral Director: After this certificate has been sign Records, 2. No 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Residence 2 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending 1 🗌 Yes 2 🗆 No Investigation Accident the To the Hospital or Atte within 24 hours after der To the Funeral Director completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifle 29d. Date signed (Month, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Sir 2010 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 08 Lawrence Allen Dickson 2010 12:27P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washington 613 N. Prospect St. Hagerstown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 1 🕱 M 2 🗆 F Min 3/16/1950 Country) Director 60 086-42-6002 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director ms 23a or 28a-f s must be notified Washington MD Hagerstown 1 Yes 2 No 10e. Street and Number 613 N. Prospect St. 10f. Zip Code 21740 10g. Citizen of What Country? Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ■ Yes 2 □ No If Yes, Give ■ TInkno הatural", or item ledical Examiner ח Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 X Married <u>≙</u> Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White ır res, Give Year or Dates. Unknown Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the N 10 welder steel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Grace Martin Robert Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 613 N. Prospect St., Hagerstown, Diane Dickson (Wife) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Rose Hill cemetery8/7/2010 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Servicture | Funeral Service Licensee Gerald N. Minnich Funeral Home WHATE 305 N. Potomac St. MD 21740 Hagerstown t 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreack or heart failure. List only she cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hepatocellular Careinoma Physician/ disease or condition 10 year Medical resulting in death) Due to (or as a c requence of) Examiner tailu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed sician and burial-transi Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown cate has been signed by page 2 should be detact Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗡 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 2 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day, Year) 5 Pending work? 1 Yes 2 No Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I only one) 29b. Signature and title of certifier 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yong Tary 3H7+1 31. Date filed (Month State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Physician/ 11:11am David C. Driscoll. Sr 2010 37 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Adelphi Prince George's 1900 Red Oak Drive 9. Birthplace (State or Foreign Country) Washington, DC If Under 1 Year 5. Social Security Number 7 Age (In vrs. last hirthday) If Under 24 Hrs. 8 Date of Birth **Funeral** Months Days Hours Min 1 🛛 M 2 🗆 F Director 578-22-1858 86 Yrs Usual Residence of Decedent or 28a-f show 10c. City, Town or Location filed within 72 hours after death with the Maryland 10a. State 10b. County 10d. Inside City Limits the Medical Examiner must be notified at Director 1 X Yes 2 No Maryland Prince George's Adelphi 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral items 23a 1900 Red Oak Drive 20783 U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status was Decedent Ever in U.S. Armed Forces? 1 \mathbb{Z} Yes 2 \mathbb{Z} No 1943-1 If Yes, Give Year or Dates. 195414. Race - American Indian, Black, White, etc. ō 1 Never Married 2 Married δ altimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", Specify. Completed 3 X Widowed 4 Divorced Caucasian 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than, Elementary/Seconday (0-12) College (1-4 or 5+) 12 Sheet Metal Construction Sheet Metal Worker other injury or other traumatic event, Be perfuit. Page 1 and 2 should be flied.
Department of Health and Mental Hy important; if item 27 is marked oth any injury or other transcript. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Helen E. Redmond Henry W. Driscoll 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Earl G. Driscoll - Son 4207 Brandon Lane, Beltsville, Maryland 20705 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State George Washington Cem 08/05/2010 | Adelphi, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeril Home. Signature of Funeral Service Lices 11800 New Hampshire Ave., Silver Spring, MD 20904 opplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sone cause on each line. 23a. Part 1. Enter the disea shock, or heart failure. Onset and Death Immediate Cause (Final Physician/ Atrial Fibrillation disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Chronic Obstructive Pulmonary Disease Sequentially list conditions, Examiner rany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Small Cell Lymphoma Completed 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Hypertension 24a. Was an has autopsy performed' within 24 hours after death.

To the Funeral Director: After this certificate 2 🗌 No 1 Yes Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 \(\sum \) Nursing Home \(5 \)X Residence \(6 \sum \) Other (Specify) 1 Yes 2 🗓 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one 29b. Signature and title ø 29c. License number 29d. Date signed (Month, Day, Year) August 2. 2010 D16495 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joel Goozh MD 10401 Old Georgetown Road, #104, Bethesda, Maryland 20814 31. Date filed (Month, Day, Year) Registrar's Signature State

Registrar

03 2010

AUG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25636 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ DOMINITZ Jack July ^D2010 31 1:30 A. M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery 10427 Windsor View Dr. Potomac If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 072-22-9476 1 □XM 2 □ F Months Days Hours Min. Aug Month 28y, Ye 1928 Vienna. Austria **Director** 81 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits Director Potomac Montgomery 1 Tes 2 1 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral U.S.A. 20854 10427 Windsor View Dr. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married 2 | No Baltimore, Maryland 21215-0036 1 Yes 2 KNo Specify: If Yes, Give Specify White 3 Divorced 4 Divorced 55 - 57Year or Dates. 15 Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Contractor Systems Engineer 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Fanny Bank Dominitz Nathan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10427 Windsor View Dr., Potomac, Md. 20854 Shirley Dominitz, spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1🎾 Burial 2 🗆 Cremation 3 🗆 Removal from State Judean Memorial Gardens Aug. 2, **2**010 Olney, Md 4 Donation 5 Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility Torchinsky Hebrew Funeral Home Washington, DC 20012 254 Carroll St., NW 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Lewy Body Dementia Physician/ disease or condition resulting in death) years Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) the attending physician and hed for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease of linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown After this certificate has been signed by the a funeral director, page 2 should be detached a | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 X No æ 26. Place of Death (Check only one Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred iniury 5 Pending To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 2 No Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of . License number D37579 29d. Date signed (Month, Day, Year) 24 August 2, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6410 Rockledge Dr., #401, Bethesda, Md. 20817 <u>Jeffrey In</u>drisano, 31. Date filed (Month, Day, Year) 37. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25637 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 29 Day Physician/ July 201[°]0 2:30 AM Vitaly Denisov Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick 100 Burlington Circle Walkersville 8. Date of Birth
(Month, Day, Year)
Mar 27, 1947 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Russia 1 🛛 M 2 🗆 F Months Hours **Director** 731-09-8679 63 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 X No Maryland Frederick Walkersville 10e, Street and Number 10g. Citizen of What Country? Funeral 100 Burlington Circle Russia Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) 5+ Building Architect permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ashukina Denisov Antonina Michael 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100 Burlington Circle Walkersville, Maryland 21793 Larisa Denisova/wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1
Burial 2
Cremation 3
Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 7/31/2010 Woodbine, Maryland 21. Signature of Funeral Service Lig Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. M0957 21029 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deat of THE PANCREAR Immediate Cause (Final ADENOCARCINOMA Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed and-trans Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown Yes 2 No 9 Unknown P.O. r signed by till Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 page certificate ! 1 🗌 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 1 Nursing Home 5 \(\text{Residence} \) 1 Residence 6 \(\text{Other} \) Other (Specify) 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ျ ieral Director, After this filled in by the funeral dil 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No Natural 5 Pending death. Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 031761

Registrar

RIANM. O CONNOR MD

501 W. SEVENTH ST FREDERICK MD 20701

person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Cedible. Amend Item 23a per me, g9060 08727 2000 deelth and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav **Physician** 3:18 PM -2010 nomas /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calisbury Vear If Under 24 Hrs. Min. Regional Medical Center Wicomico ninsula 8. Date of Birth (Month, Day, Year) If Under 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1**⊠**M 2□ F 224-74-162 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ☑Yes 2 ☐ No Director VA Accomack Velu hurch 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ortant: If item 27 is marked other than "natural", or items 23a or Injury or other traumatic event, the Medical Examiner must be I 23415 S. H 32350 ane Funeral a Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 12. 11 Marital Status Black, White, etc. Armed Folices:
1 ☑ Yes 2 ☐ No
If Yes, Give
Year or Dates: 1969-1973 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ockhead ogistics Mat permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygic Important: If item 27 is marked other any Injury or other traumatic anawash 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ್ತ 1 homas DUKES Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 23415 VA Azolra Deborah Dukes ane Church Baltimore, 20c. Location - City of Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Natural 2 ☐ Cremation 3 ☐ Removal from State lemperanceus IIz, VA Chincologue, VA 23336 4 ☐ Donation 5 ☐ Other (Specify) 7-24-2010 Taylor Cemelay 21. Signature of Funeral Service Licensee Solver Funeral mand Home, Inc. 6327 Church 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Myocardial Infarction** Approximate Interval Betwee Onset and Deat Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** CERTIFICATION APPROVED BY MEDICAL EXAMINER Sequentially list conditions, if any, leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-trar Due to (or as a consequence of): P.O. Box 68760. signed by the attending physician d be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Tyes 2 No 3 Probably 4 Unknown Completed peen s page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 1□ Yes Division or Vital 25. Was case referred to medical examiner?

1 → Yes 2 □ No funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Director: After 5 ☐ Pending investigation Natural 1 ☐ Yes -2 death. 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital or Al 24 hours after of 4 ☐ Homicide 24 hours Funeral 12-Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely To the I within 2. and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) B 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Glenn D. Wetter WD real In Chinestes 0295 31. Date filed (Month, Day, Year) AUG 0 2 2910 32. Degistrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25639 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 29 Day July Physician/ 2010 Zellmer Echard 4:47 A M Susan Medical 4a. Facility Name (if not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Bethesda Suburban Hospital 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🗆 M 2 🗶 F Months Hours Min (Month, Day, Year Country) **Director** 352-36-8587 65 9 1944 Ohio Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 🗌 Yes 2 🔀 No Maryland Frederick Mount Airy 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? "natural", or items 23a o Funeral 13234 Manor Drive South 21771 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?
1 ☐ Yes 2X No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. 3 Widowed 4 Divorced Completed White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry permit. Page 1 and 2 should be filed within 72 r
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any injury or other traumatic event, the Madric once. (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Membership Elementary/Seconday (0-12) Vice President 5± Services Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Warren Zellmer O'Toole Kathleen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21771 Paul Edward Echard - Husband 13234 Manor Drive South, Mount Airy, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Arlington National 08/23/2010 Arlington, Virginia 22. Name and Address of Facility
Molesworth-Williams P.A., Funeral Home
26401 Ridge Road, Damascus, Maryland 21. Signature of Fineral Serv of Licens 20872 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Pneumonia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Lymphoma Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed for use as the burial-transi and that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) should be detached 9 Unknown g 🔲 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown Records, Renal Failure 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy page 2 performed? this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Division of Vital the funeral director, 26. Place of Death (Check only one) Be examiner? Hospital 1 ☐ Yes 2 ☐XNo မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at s after death. Certificate: 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 3 Sulcide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) 24 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2 only one) 29b. Signature and titl 29c. License number 29d. Date signed (Month, Day, Year) D26259 July 29, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

01-1

Registrar
DHMH 17 Rev 7/2009

State

Kaufman Ava

31. Date filed (Month, Day, Year)

Bethesda, Maryland

20814

8218 Wisconsin Avenue,

32. Registrar's Signature

Green

			Plea	ase Type or Pr						-		_	∍.	
			For State Registrar	State of IV	larylar		artment of F tificate of D		and Me	_	giene Reg. N	0010	25	640
	Physicia	an/	1. Decedent's Name (First, Middle	. ,					2	. Date of De Month	ath		3. Time	of Death
	Medi Examir	cal	4a. Facility Name (if not institution	Maybell Ra n, give street and number)	acine	Eder	4b. City, Town, or	Location	of Death	Augus		2010 c. County of De		O A M
-			320 Hollingswo				E1ktor	n				Ceci1	atti	
	Funeral Director		5. Social Security Number 213-12-4013	1 M 2 V F	je (I <i>n yr</i> s. <i>l</i> : 90	ast birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	Date of Bir (Month, Dauly 22	th ly, Year)	9. E	irthplace (State ountry) Marylar	or Foreign
	nd how at	<u>_</u>	Usual Residence of Decedent 10a. State 10b. County			y, Town or Loc	eation			<u>ury 22</u>	- 1 -	720	10d. Inside	
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show minority or other traumatic event, the Medical Examiner must be notified at once.	Director	Maryland Cec:	i1		E1kton								es 2 🗆 No
	ith the 3a or 3 t be n		10e. Street and Number	. 1 . 0			10f. Zip Code				10g. C	itizen of What (•	
	eath w	Funeral	320 Hollingswo	12. Was Decedent	Ever in U.S	S. 13. V	21921 Vas Decedent of Hi		igin? (Specify	/ Yes or No-		United 14. Race - An		
36	after de I", or it camine	<u>چ</u>	1 Never Married 2 Marr	1 163 2 10	No		Vas Decedent of Hi Yes, specify Cubar			an, etc.)		Black, Wh	ite, etc.	
8	hours natura ical Ex	Completed	3 🕅 Widowed 4 🗆 Divorced	Year or Dates.			ent's Usual Occupa				16b k	Specify: W	hite	
218	nin 72 ne. than "r e Med	dmo	Elementary/Seconday (0-12)	est grade completed) College (1-4 or s	5+)	(Give k life. D0	ind of work done d NOT use retired)	lunn <i>g m</i> os	t of working		100. 1	Electr:	,	r
d 2	Hygier Pther i	BeC	11. 17. Father's Name (First, Middle, L	asti		Li	ne Forema		er's Name (F	Von A. A. A. C. al. al. a.	A 4= 1=1= ==	Manufa	cturing	
/lan	d be filed Mental Hy, arked oth	မ	William David R	•					ra Fut		warden	Surname)		
Maryland 21215-0036	12 should be the and Me the and Me 27 is mark	3	19a. Informant's Name/Relationsh				g Address (Street a							
	f Healt f Healt item 2 other		William H. Ede 20a. Method of Disposition	r, III/Son	20b. P		Chapman L	00p,	The V			FL 32.		_
Baltimore,	Page 1 ment of ant: If it ury or o		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		i Imn	naculat	atory or other place Ce On Cemete	j 2.	August 2010	10,		Cherry	,	4D
Balt	permit. Page Department of Important: If any injury or once.		21. Sign ture of Funeral Service L	icensee		22.	Name and Addres	s of Facilit	y Hick		e fo	r Fune	als, P	.A.
			23a. Part 1. Enter the disease, or	complications that caused	d the death	n. Do not enter	103 W.					kton, ľ	Approxima	
F	hysician/		shock, or heart failure. List or Immediate Cause (Final disease or condition	nly one cause on each line	PIG	3	whic L						Interval Be Onset and	etween
	Medical Examiner		resulting in death)	Due to (or as	a consequ	ence of):	<u> </u>	,,,,,,,					1190	Cri
		iner	Esquentiary list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequ	ence of):								
p.	executed an and rial-transit	Examiner	Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to (or as a	CONSEGU	ence of:								
<u>.</u>	69 ⊭.⊱ I	_	Toodking in Godkin Edge	d	2 00110044	crice ory.								
3876	ing ph	/Med	IF FEMALE:	20. 16										
Box 68760	eath ce attenc	Physician/Medica	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 🗀 Fetal	death 3 🗌	Ectopic pregnancy Other (specify)	/				23d. Date of d	elivery Day	Year
P.O. E	trine d by the stached	Phys	9 Unknown	9 Unknown					-					
ა ე. :	signed Id be d	Completed by	Part II. Other significant condition Carund Stene	ssis, breas					.			ıse contribute t □ No 3 💢 I		
Vital Records,	aw requase beer 2 shou	plete	austic star	1571						24a. Was a	an	24b. Were a	topsy findings	available
ğ	cate h									autop perfor 1 Yes		death?	s 2 No	cause of
VIta	ysician s certif director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:		ER/Outpatient	Othor		h (Check onl					
0	ing rin		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injur	у :	28b. Time of injury	28c. Injury work?	at		Describe ho		Other (Spe	city)	
DIVISION	r death c tor : /	Certificate:	2 ^r Accident Investiga 3 Suicide 6 Could n	ation ot be	rv - At hon	ne, farm, stree	The same of the sa	/es 2 🗌		Longtion (C	trant and	d Number or Ru	end Davida Muse	4
ב ב	irs after al Dire		4 ☐ Homicide determir	building, etc	. (Specify)				201.	City or Town			rai Houte Num	oer,
2	To use nowher or Attended in propagate. The law requires that the death certificate be, within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the but	Medical	Check 2 - Medical Ex	Physician: To the best of a caminer: On the basis of ex Nurse Practioner: To the	amination	and/or investig	ration in my opinion	death occ	curred at the	timo data an	d place	and due to the	cause(a) and m	anner stated.
F 5	withi To th		29b. Signature and title of certifier	2 1			29c. License		211			e signed (Mont		
	,	4	30. Name and address of person w	the completed cause of de	ath (Item :	23a) (Type Pri	1 0003	93	24		Aug	4115	, 2010	
	6		Meres Perkin	MD 349 6	5. PU	lasti		Elk.	en,	MO o	219	21		
	State Registra		31. Date filed (Month, Day, Year) AUG 1 7 201	32. Registra	r's Signatu	bare	,					to flame		
- HM	H 17 Rev 7/200	20	TO THE PARTY OF TH		1	years								

Maybell Eder

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25641 Certificate of Death 2. Date of Death Physician/ Month July Day 2010° Blanche Elmira Boyd Eberhardt 31 1300 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Calvert Manor Nursing Home Cecil Rising Sun Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Aug. 28 9. Birthplace (State or Foreign Funeral 7. Age (In vrs. last birthday) Year) 917 1 🗆 M 2 🔽 F 92 Maryland Director 213-18-3166 Usual Residence of Decedent "natural", or items 23a or 28a-f show idical Examiner must be notified at 10a State 10b. County 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Cecil Perryville 1 ☐ Yes 2 🎾 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1518 Frenchtown Road 21903 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎖 No Specify: Completed 3 X Widowed 4 □ Divorced White Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry V.A. Medical Center (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Perry Point, Maryland Ten Years EKG Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Henry Boyd Frances Hackney 19a. Informant's Name/Relationship (Type, Print) 196 Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Codal 903 Sumpter Drive, Perryville, Maryland 21903 James L. Eberhardt (son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mark's Cemetery 08/04/10 Perryville, Maryland ure of Funeral Service Lidens ²² Name and Address of Facility of Son Funeral Home, P Perryville, Maryland 21903-0766 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causing each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ thund disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 1 Live Birth
4 Pregnant
9 Unknown in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown gnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 1 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospita 2 X No Other: မြ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending Accident 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatuje and title of certifier 29d. Date signed (Month, Day, Year) 0 of person who completed cause of death (Item 23a) (Type, Prin 31. Date filed (Month, Day, Year, 32. Registrar's Signature

State Registrar 10-05658 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Charles Thomas Ester, Sr. State of Maryland / Department of Health and Mental Hygiene 25642 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Da July 28, 2010 Charles Thomas Ester Jr. 1815 hrs **Medical Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death . County of Death Baltimore Johns Hopkins Bayview Medical Center **Baltimore** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** 213-46-0564 Months Days Min. Hours 63 Yrs 02/04/1947 Country) MD Directo 1XM 2 F Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits any 10b. County Baltimore Fort Howard MD 1 Yes 2 X No or 28a-f show notified at once. Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 7519 Fort Avenue 21052 items 23a Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 2 X No Yes White 3 X Widowed If Yes, Give Year 4 Divorced 1 Yes 2 X No specify: Specify: other than "natural", ģ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Truck Driver Delivery Baltimore, MD 21215-0036 12 4 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Charles Thomas Ester Sr. Elva Creamer Important: If item 27 is marked 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1166 Appleton Road, Elkton, MD 21921 Angela Ester / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Burial 2 X Cremation 3 Removal from State United Crematory 08/01/2010 Newark, DE Donation 5 Other Specify Services 22 Name and Address (Facility Family Funeral Home 635 Churchmans Road, Newark, DE 19702 21. Signature of Funeral Service Li 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and (Medical a. Atherosclerotic Cardiovascular Disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): se: Enter Underlying Couse (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last

signed by the attending physician and be detached for use as the burial - transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, After this certificate has the Hospital or Attending Physician; Director: hours after death within 24 hours a

Physician/Medical

Completed by

Be

Certification:

Medical

State Registrar

29b. Signature and title of certifie

Carol Allan, MD

31. Date filed (Month, Day, Year)

UNPENDED A	AMENDED					
	23c. If yes, outcome of pregnancy		-	23d. Date of de	livery	
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (Spa		ncy	Month	Day	Year
Part II. Other significant conditions co	entributing to death but not resulting in the underlyin	g cause given in Part I.	23e. Did toba	cco use contribu	te to the cau	se of death?
			1 Yes	2 No 3	Probably 4	Unknown
			24a. Was an autopsy performe	prio	r to completi	ndings available on of cause of
25. Was case referred to medical		26.Place of Death (Check o	nly one)			
examiner? 1 ✓ Yes 2 No	pital: 1 Inpatient 2 🗹 ER/Outpatient 3 🔲 I	DOA Other Nursing	Home 5 Re	sidence 6	Other:	
27. Manner of Death		28c. Injury at Work?	28d. Describe how	injury occurred		
1 V Natural 5 Pending 2 Accident Investigation	(Month, Day,Year)	1 Yes 2 No				
3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factor (Specify)	y, office building, etc.	28f. Location (Stre or Town, State		or Rural Rout	e Number, City
(oncon only	To the best of my knowledge, death occurred at the	· ·				(s)

29c. License number

O.C.M.E

111 Penn Street, Baltimore, MD 21201

ORIGINAL

Death

29d. Date signed (Month, Day, Year)

July 29, 2010

32. Registrar's Signature

and manner stated

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First_Middle_Last) 2. Date of Death July Richard Furmanek 30 Day 2010 4b. City, Town, or Location of Death 4c. County of Death Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Mar. 22 7. Age (In yrs. last birthday) Min. 1 ▼ M 2 □ F Months Days Hours 56 Yrs 1954 10b. County 10c. City, Town or Location

"natural", or items 23a Baltimore, Maryland 21215-0036 al Hygiene. I other than " n and Mental | To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

For State

Physician/

Daniel 07:50A M Medical 4a. Facility Name (if not institution, give street and number) Examiner Casey House Hospice 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 458-04-2103 Director 0k<u>Tahoma</u> Usual Residence of Decedent or 28a-f shov 10a. State filed within 72 hours after death with the Maryland event, the Medical Examiner must be notified at Director 10d. Inside City Limits 1 Yes 2 X No Montgomery Olney Md. 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20832 4620 Bettswood Drive United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 ☑ Yes 2 ☐ No 1974-If Yes, Give Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced 1980 White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Radiology Health Care Administrator 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked or any injury or other traumatic eve ٥ McFadden Louise Rudolph F. Furmanek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4620~Bettswood~Drive,~01ney,~Md.~20832Barbara A. Furmanek / Wife 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗆 Burial 2 🖼 Cremation 3 🗀 Removal from State 7/31/10 Alexandria, Va. Metropolitan Crem. 4 Donation 5 Other (Specify) Sign were of Fur all Service L Name and Address of Facility Muriel H. Barber Funeral Home P. O. Box 5038, Laytonsville, 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2 Years Immediate Cause (Final Physician/ disease or condition Glioblastoma Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death 2 🗆 No been signed by the should be detached 9 Unknown g 🗌 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been sig , page 2 should b 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performe ours after death.

eral Director: After this certificate I filled in by the funeral director, page 1 Yes 2 No 1 🗌 Yes 2 X No æ 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Other: 1 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA Hospice 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1≝ Natural work? 1 ☐ Yes 2 ☐ No 5 Pending injury Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 - Homicide City or Town, State) within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29d. Date signed (Month, Day, Year) D 37142 July 30, 2010 lena Y 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20850 Geoffrey Coleman, M.D. 1355 Piccard Drive, Rockville, Md. 20 TIVA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG Registrar (RALLERAND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Vivian W. Fleming 11:45 a lulv Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 7. Age (In yrs. last birthday) 90 yrs If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 253-30-7060 Months Days Hours Min. Georgia Director Usual Residence of Decedent 28a-f sho 10c. City, Town or Location event, the Medical Examiner must be notified at 10d. Inside City Limits Director WV Jefferson Charles Town XXYes 2 No 10f. Zip Code 25414 10e. Street and Number 10g. Citizen of What Country? United States 23a or Funeral 538 Eagle Avenue than "natural", or items 130 6 11 Marital Statue 12. Was Decedent Ever in LLS Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Deceden _ Armed Forces? 1 Yes 2 XXNo Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Teacher Public Schools and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ John T. Williams Ada Ross Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12014 Leatherbark Way, Germantown, MD 20874 permit. Page 1 and 2 st Department of Health a Important, If item 27 is any injury or other tra William S. Fleming-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1. Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Pleasant View Memory Gardens 8/5/2010 Martinsburg, WV 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Melvin T. Strider Co. PO Box 388, Charles Town, WV 25414 23a. Part Anter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequer Cause (Disease or linjury that initiated events and the burial-tran Due to (or as a consequence of): resulting in death) Last physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the at d be detached fo Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕻 Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of 24a, Was an has autopsy death? certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Certificate: To 1 🗌 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) hours after death. uneral Director: After this filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 No Investigation Could not be Accident Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital within 24 hours a To the Funeral C Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medigal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tit \$003757 29d, Date signed (Month, Day, Year) 120061 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ahmed Y. Heshmat, MD, 10110 Molecular Dr., Suite 200, Rockville, MD 20850 31. Date filed (Month, Day, Year) State AUG 4 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Mary				Mental Hy		2 2 5	C1.5
			Registrar 1. Decedent's Name (First, Middle, Last)		Cer	tificate of D	<i>Death</i>	2. Date of De	neg. No. O		645
	Physicia Medi			Julia Faul	kner			Month		ear 4	me of Death
	Examir		4a. Facility Name (if not institution, give si			4b. City, Town, or	Location of Death	1	4c. County of	Death	
1	F		5. Social Security Number 6, Sex		Unke yrs. last birthday)	If Under 1 Year	S DUC V	✓ 3. Date of Bir		mica	
	Funeral Director	П		M 2 🕱 F 7. Age (m)	91 Yrs.	Months Days	Hours Min.			Country) eLawar	tate or Foreign
	d d	_	Usual Residence of Decedent 10a, State 10b, County	100	c. City, Town or Loc	ation.		<u></u>			
	larylan ka-fsh ifiled a	ecto	Maryland Caroli		Ridgel					1	ide City Limits
	the M	ä	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha		
	h with ns 23a nust b	Funeral Director	10789 Holly Road			21660			Inited Sta	tes of	America
"	r deat or iten niner r		11. Marital Status 1 Never Married 2 Married	2. Was Decedent Ever i		as Decedent of His Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American India White, etc.	an,
9036	rsafte iral", d Exam	Completed by	3 X Widowed 4 □ Divorced	1 ☐ Yes 2 🗶 No If Yes, Give Year or Dates.	1	☐ Yes 2 🛣 No	Specify:		Specify:	Caucas	ian
15-0	2 hou "natu edical	plet	15. Decedent's Edu (Specify only highest grad		16a. Deced	ent's Usual Occupa ind of work done di	ation uring most of work	kina	16b. Kind of Busin		
12/2	ithin 7 iene. r than the M	Con	Elementary/Seconday (0-12)	College (1-4 or 5+)	life. DC	NOT use retired) $11\mathtt{ing}$ C16	_		Manufact	urino	Company
þ	filed wall Hygial Hygia	Be	17. Father's Name (First, Middle, Last)			111118 010		ne (First, Middle,	Maiden Surname)	urring	Company
<u>₹</u>	ald be Menta narked	₽		hony Deery	<u> </u>		Ste	ella Fr	ances Ve	gelews	ki
Maryland 21215-0036	2 shou th and th is n 27 is n traurr		19a. Informant's Name/Relationship (Type Norma Schultz	_{e, Print)} Daught		g Address (Street a. 9 Holly F			r, City or Town, State	a, Zip Code) 21660	
) <u>a</u>	f and if Heal item (20a. Method of Disposition	2	Ob. Place of Dispos	sition (Name of		Date Date	20c. Location - Cit		ite
<u>ii</u>	Page ment c ant: If ury or		1 ☐XBurial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Concord	atory or other place Cemetery		1/2010	Federalsb	urg, M	aryland
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: I firem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of juneral Service Licensee	10h					eral Home	•	01.600
			23a. Part 1. Enter the disease, or complic	cations that caused the					enton, Ma		21629 ximate
P	nysician/		Immediate Cause (Final	CERROR						Interva	al Between and Death
	Medical Examiner		disease or condition resulting in death)	Due to (or as a con		1	CC 10 PCA	1 , 1	ulle	1	
	LXammer	ē	Sequentially list conditions, b	Due to fee as a second	-100						
3	red Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a con	suquence our						
	execu an and rial-tra	Ex	that initiated events c resulting in death) Last	Due to (or as a con	sequence of):		·				
f Vital Records, P.O. Box 68760	ate be executed oblysician and the burial-transit	dical	d	-							
687	attending pl	N/Me	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pre	egnancy				23d. Date o	f alatinan	
Вох	e atter	Physician/Me	in the past 12 months?	1 Live Birth 2 4 Pregnant at time		Ectopic pregnancy Other (specify)	·		Month	Day	Year
P.O. I	es triat trie des signed by the a be detached i		g ☐ Unknown Part II. Other significant conditions conf		t regulting in the us	derhing cours in	na in David I				
S, P	signed d be d	Completed by	Tax II. Other significant conditions com	inbuting to death but no	resulting in the di	derlying cause give	mmrani.	1 🗆 '	bacco use contribut		of death?
ord	s been si should I	olete						24a. Was a		e autopsy findi	
Rec	ate has	Som							rmed? deat	to completion h? Yes 2	
tal	certificate ha	Be	25. Was case referred to medical examiner?	spital:			ce of Death (Chec		4510	- 11	
f Vi	rthis c ral din	2	1 Yes 2 No		ER/Outpatient	3 DOA Other	4 L Nursing Ho		lence Other (S	pecify) Ho	SPICE
ision o	ath. r: After e fune	icate	Natural 5 Pending Accident Investigation	(Month, Day, Yea		work?	res 2 🗌 No	28d. Describe n	ow injury occurred		İ
Division of Vital Records,	irecto	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A		et, factory, office		28f. Location (S City or Tow	treet and Number or	Rural Route N	Number,
Di	eral D	cal C	29a. Certifier Certifying Physic			and at the time	dete and slane se				- "
H	in the first plan of American Francisco. To the Funeral Director: After the completed filled in by the funeral	Medical	(Check only one) 3 Certifying Physic	ian: To the best of my kir: On the basis of examin Practioner: To the best of	ation and/or investig	ation, in my opinion	 death occurred a 	t the time date a	nd place, and due to	the causels) an	d manner stated.
P.	within 2 To the comple		29b. Signature and title of certifier		, , , , , , , , , , , , , , , , , , , ,	29c. License	number		29d. Date signed (M	onth, Day, Yea	
			10			0	00594	(0	7/27	110	
_			30. Name and address of person who con		Item 23a) (Type, Pr	int)	00594 SACG	RUDI	7/27/	2/18	2
	Stat	e	31. Date filed (Month, Day, Year)	2. Registrar's Si		4.3	3170	3007	000	0,00	
	Registra	ir	JUL 3 0 2010	The same	B. Brav	UNIO DE LA CONTRACTION DE LA C					

DHMH 17 Rev 7/2009

LOPS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year Louise Fisher July 12:37 PM 2010 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Salisbury Rehabilitation + Nursing Cin. Salisbury Wicomico If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 214-10-0893 1 □ M 2 🔀 F Months Days Hours Min. Director 11/23/1921 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 200. any injury or other traumatic event, the Marter 1. 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 □ No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1514 Riverside Dr., Apt. Bl14 21801 USA by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2X No Specify: white Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) housekeeping supervisor hospital 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Willie O. Beach Nellie M. Graham ပ 19a. Informant's Name/Relationship (Type. Print) Harry Fisher/spouse o. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1514 Riverside Dr., Apt.Bll4, Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Wicomico Memorial 4 ☐ Donation 5 ☐ Other (Specify) 8/3/2010 Salisbury, MD Park 21. Signature of Funeral Service Lig PHOTIOWAY Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (o) as a consequence of): Examiner sif any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Physician/Medical yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 1 ☐Yes 2 ☐No 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-trar

Medical

Day, Year) State AUG 0 2 2010 Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

raver Registrar's Signati

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 El Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Ave,

hisburg

State Registrar

DHMH 17 Rev 1/2001

29a. Certifier

29b. Signature and title of certifier

Russell Alexander MD.

31. Date filed (Month, Day, Yes 32. Regist 's Sign

30. Name and address of person who completed cause of death (Item 23a)

and manner stated

Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

July 29, 2010

OCIME

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 7 4:30 AM Lee Ganey Jr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 101 Kate Wagner Rd. Westminster Carroll If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 1 □XM 2 □ F Months Days Hours Min Director 577-48-8744 1936 Washington DC Usual Residence of Decedent 28a-f shov should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits must be notified 1 🗆 Yes 2 🔀 No Maryland Carroll Westminster 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 101 Kate Wagner Rd U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. \$ 1 Never Married 2 Married 2 No Maryland 21215-0036 1 Tes 2 No Specify: 3 Widowed 4 Divorced If Yes, Give Completed Specify: Year or Dates White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Construction event, 1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic. Lee Ganey, Sr. Inez Banta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Ganey (Son) 101 Kate Wagner Rd. Westminster, MD 21157 Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 Donation 5 Other (Specify) Chesapeake Crematory 8/7/2010 Beltsville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rendon/Hale Funeral Home MACAL 9013 Annapolis Rd. Lanham, MD 20706 23a. Pert 1. Enter the disease plications that caused shock, or heart fallure. List only one cause on each line. plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical D e to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Medical Box 68760 IF FEMALE: Physician/ 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death Month Day Year 9 Unknown 9 Unknown P.O. ģ signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed: The certificate 1 Yes 2 No or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner eath 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred

Division of Vital

State Registrar

Medical

atural

Accident

Suicide

29a. Certifier

(Check only one) 29b. Signature and title

31. Date filed (Month, Day, Year)

AUG 0 4 2010

5 Pending

Investigation

determined

6 Could not be

who completed cause of death (Item 23a) (Type, Print)

injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

work?
1 Yes 2 No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 25649 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Erro1 Lynn Griffith 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Marvland Hagerstown 5. Social Security Numbe If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months Days Min 220-42-6181 Hours April 30 ^(ear) 1946 Director 64 Maryland Usual Residence of Decedent 10a. State 10b. County be filed within 72 hours after death with the Maryland Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 28a-f Maryland Washington Keedysville 1 Tes 2 X No 10e. Street and Number 'n 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 5855 Red Hill Road U.S.A. 21756 items 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, rmed Forces?
2 Yes 2 No 1967-Black, White, etc. 1 Never Married 2 Married ō þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced Completed Specify 1969 White intal Hygiene. ked other than "natura c event, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor State of Maryland marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 7 is marked o ဂ္ UNKNOWN Department of Health and Men Important: If Item 27 is marke any injury or other traumatic Rayetta Marie Griffith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sh ment of Health a ant: If Item 27 is Linda E. Griffith / Wife Post 5855 Red Hill Road Keedysville. MD 20a. Method of Disposition
1 ☐ Burial 2 🋣 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Stauffer Funeral Home 08-04-2010 Frederick. Maryland 21. Signature of Fuperar Service Licer 22. Name and Address of Facility Bast-Stauffer Funeral Home. 7606 Old National Pike Boonsboro. MD 21713 Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause on is that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest is or each line. 23a. Part 1 Approximate Interval Between Immediate Cause (Final Onset and Death ARdIAC Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner ta 5+9+ KRA? Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant 5 Other (specify) Month Year Pregnant at time of death Day 2 No is certificate has been signed by the director, page 2 should be detached 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral directors. 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 X Natural iniury 5 Pending 2 Accident
3 Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year. ath (Item 23a) (Type, Print) 30. Name and address of person Pennsylvania MO

State

Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Yea

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 25650 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2010 Physician/ August 1 6:55 P M Marjorie Marie Gallery Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Casey House If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5 Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral New York Min. Months Davs Hours (Month, Day, Year) DEC 7, 1942 1 🗆 M 2 🔀 F Dec Director 67 094-34-6184 Usual Residence of Deceden 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County must be notified at with the Maryland Director 1 ☐ Yes 2 🔀 No Gaithersburg Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 5 10e. Street and Number items 23a Funeral United States 20886 9214 Weathervane Place death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. the Medical Examiner Armed Forces? 0 ğ 1 Never Married 2 Married Maryland 21215-0036 nours after 1 Yes 2X No Specify: If Yes, Give Year or Dates Specify: White "natural", 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Decedent's Education (Specify only highest grade completed) 72 1 and Mental Hygiene. Is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Church Supplies Manager Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be Department of Health and Menta Important. If item 27 is marked any injury or other. မ Elinor Reif Ferdinand Biedlingmaier June Joseph 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert M. Gallery/husband Gaithersburg, Maryland 20886 9214 Weathervane Place Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 ☐ Burial 2 😾 Cremation 3 ☐ Removal from State inal Journey Crematory 8/3/2010 Woodbine, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licen Going Tioness Cremation Service P.O. Box 784 trans Beverly L. Heckrotte, P.A. Clarksville, MD 21029 M00957 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ End Stage Renal Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Peripheral Vascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): sician and burial-transit Exami The law requires that the death certificate be executed Hypertension Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death ed by the a detached t signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Stage IV Lung Cancer Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2X No page 2 s certificate or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 2 XNo 1 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) Hospice funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 X Natural 5 \square Pending nours after death.

Neral Director: Aft
filled in by the fur 2 🗌 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) hin 24 hours a' the Funeral C mpleted filled Medical 1X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2.

To the F

complet To the only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Jecelyne Kouertchou, ms

10

State Registrar 6001 Muncaster Mill Road Rockville, Maryland 20855

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32.

Registrar's Signature

Jocelyne Kouatchou,

UG U 3 2010

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ Year 29 2010 P Medical <u>Isabel Pricila Brizuela Vda De Gutierrez</u> 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Silver Sprinc Montgomery Holy Cross Hospital 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) Funeral Days Hours Min (Month, Day, Vear 1 □ M 2 🔀 F Director 76 07/08/1934 Salvador none Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛣 No Prince Georges College Park Maryland 10f. Zip Code 10g. Citizen of What Country? Funeral Cherry Hill 9314 Rd 20740 Salvador 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. ģ 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 within 72 hours after 1 XYes 2 ☐ No Specify: "natural", 3 Nidowed 4 Divorced Completed Salvadorian White Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Jose Santos Brizuel<u>a</u> Mariana Canales 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sl ment of Health a tant: If item 27 is William Gutierrez (Son) 9314 Cherry Hill Rd. #815 College Park, MD 20740 20c. Location - City or Town, State La Union 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cementerio Municipal: Aug. 4, 2010 El Salvador Signature of Funeral Service Licensee 22. Name and Address of Facility Rendon/Hale Funeral Home Ro 9013 Annapolis Lanham. Part 1. Enter the disease, or copylications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart-failure. List only one cause on each line. Approximate Interval Between Onset and Death Minutes mediate Cause (Final Myocardial Infarction .Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last ending physician ause as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No jo Month 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknowi Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been signer Physician: The law requires 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performe certificate 1 Yes 2 No 2 XN Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) director Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 🗌 No ည 1 X Yes 1 Inpatient 2 X ER/Outpatient 3 IDOA this 28a. Date of injury (Month, Day, Year) funeral Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending work? 1X Natural 5 Pending injury 2 No Accident Investigation s after death by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined filled in I hours 24 hours e Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

The dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practions the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 7/29/2010 D64008

State Registrar

31. Date filed (Month, Day, Year) AUG O

Eddie

O. Name and address of person who co

Fernandez

32. Registrar's Signature

pleted cause of death (Item 23a) (Type, Print)
1500 Forest Glen R

ni

Rd Silver Spring, MD 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25652 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Loretta Grace Garner Month 07/31 1/2010 Year 5:00 a м Medical 4c. County of Death Calvert 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 3065 Cox Road Chesapeake Beach 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 😿 F Director Yrs 0173071928 208-18-2013 82 Usual Residence of Dece shov 10a. State 10b. County er than "natural", or items 23a or 28a-f sho the Medi-al Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Calvert Chesapeake Beach 1 🗆 Yes 2 ဳ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3065 Cox Road 20732 U.S.A. death \ 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🛣 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ğ Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: 3 Widowed 4 Divorced White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F မ Ernest Kraepel Emma Marie Beech 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau once. Karen Pearson/Daughter 455 Cross Creek Drive, Huntingtown, MD 20639 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Baptist Cem 08/05/2010 Upper Marlboro, MD 21. Signature of Funeral Service Lipensee Lee Funeral Home Calvert, P.A. Lisa M. Mounts Blvd. Owings. MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) canc Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the Innertal director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗌 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 1 \square Yes Hospital: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 00059061 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JRW 15

DHMH 17 Rev 7/2009

State Registrar

Arati Patel, 31. Date filed (Month, Day, Year)

32. Registrar's Signature

MD 110 Hospital Road, Suite 212, Prince Frederick, MD 20678

10-06008

ames Calvin F	lous		e of Maryland							_egib	ie. 2 ∩	10	25653
		1- For State Registrar			rtificate of					Reg. No	20	1 0	20000
Physic Medical Exam		Decedent's Name (First, Middle,L James Calvin Ho							2. Date of I Month August		Year		3. Time of Death 2026 hrs
		4a. Facility Name (if not institution, o				4b. City,	Town, or	Location of D		- 4	tc. County o		
		Washington County Hos	<u> </u>				erstown				Washing		
Funeral Director		7		(In yrs, I	ast birthday)	If Un	der 1 Year		Min		·	Foreign	nplace (State or
Director	ļ	214-32-4790 1	X M 2 F		83 _{Yrs}	i.			July	13,	1927	Cou	ntry) Marylan
any		10a. State 10b. County		10c. City,	, Town or Locat	ion							10d. Inside City Limits
Aaryland 28a-f show 1 at once.	 	Maryland Washing	ton	Sh	narpsbur	g							1 Yes 2 No
Maryland · 28a-f sho	Director	10e. Street and Number			-	10f. Zi	ip Code		-	10g. C	itizen of Wh	at Count	ry?
hours after death with the Maryland "natural", or items 23a or 28a-f sht Examiner must be notified at once		7207 Dam 4 Road	Lie W. e. iii		o L.o.u.		1782		, a	US		A	and all and Direct
ath wi	Funeral	11. Marital Status 1 Never Married 2 Marrie	12. Was Decedent Armed Forces?						(Specify Yes or erto Rican, etc.)		14. Race - White		an Indian, Black,
ufter de ul", or	by Fu	3 Widowed 4 Divorc	1 Yes 2 and If Yes, Give Year or Dates:	X No	1	Yes :	2 X No	specify:			Specify:	Whi	te
nours a		15. Decedent's Education (Specify	only highest grade com		16a. Deceden			ion (Give kind DO NOT use		16b.	Kind of Bus	siness/In	dustry
7 3 7	ompleted	Elementary/Secondary (0-12)	College (1-4 or 5	5+)	Farmer	•					armi no	•	
5-0036 led within 72 hours Hygiene. other than "natur the Medical Exami	Com	17. Father's Name (First, Middle, La			rarmer	·		18.Mother's N	ame (First, Midd		armino n Surname)	3	
21 be fi rked ent,	Be	Charles Buchanan							rlene D				
ID 21 2 should and Mer 27 is man	To	19a. Informant's Name/Relationship									nber, City or Town, State, Zip Code)		
≥ g # g #		Lucille L. House 20a Method of Disposition	r (wire)	20b. F	/ZU / Place of Dispos				rpsburg		Location -		own, State
Baltimore, permit. Pages 1 a Department of He Important: If ite		1 X Burial 2 Cremation		10	crematory or oth			rale O	-13-2010	, _{1,7}	11:0		+ Maserland
Baltimo permit. Page Department of Important:	1	4 Donation 5 Other Special 21. Signa of Fun re- ervice Lice		GL 6	eenlawn 22. N				-13 - 2010 Sborne				rt,Maryland
in In Dept.	9	fay Co.	M		425) S.	Conc	cochea	gue St.	Wil	liamsp	port	, MD 21795
Physician /Medical		23a. Part I. Enter the disease, or cor failure. List only one cause on	each line.										Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)	Bue to (or as a conse			scl	eroti	c Card	liovascu	lar	Diseas	se	Death
		Sequentially list conditions,	b	quonico	.,.								
	miner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse	quence of	f);								
d iit	Exam	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence of	f):								
e executed sian and ial - transit	dical E	▼ UNPENDED	dAMENDED	220 2	27 per n		007 0	10 10)				
760, icate be er physician the burial	ledic	IF FEMALE:	23c. If yes, outcom			ne g	907 5	9-10-10) VL	12	3d. Date of o	teliven.	
ox 68760, ath certificate be attending physic or use as the bur	an/N	23b. Was decedent pregnant in the past 12 months?	1 Live birth		2 Fel	tal death	3 [Ectopic pre	gnancy	12.	Month	Da	y Year
Box 68760, death certificate by the attending physic de for use as the bur	Physician/Mec	1 Yes 2 No 9 Unknow	vn 9 Unknown	ime of de	ath 5 Oth	ner (Spe	ecify)						
that the de detached f		Part II. Other significant conditions		but not re	esulting in the u	nderlyin	g cause gi	iven in Part I.	23e. Di	id tobacco	use contrib	oute to th	ne cause of death?
rds, P.O. requires that the been signed by hould be detact	d by		<u>,</u>						_ 1 🗆	Yes 2	No3	Proba	bly 4 🗹 Unknown
cords law requi has been 2 should	ompleted									ntopsy	pr	ior to co	psy findings available mpletion of cause of
Reco	Com									erformed? es 2		eath? Yes	2 No
Vital Recysician: The his certificate director, page	Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatier			٠, ١,	1/	of Death (Che		7		la.	
of Vit ling Physic After this	유	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injur	v	ER/Outpatient 28b. Time of Ir		DOA	y at Work?	rsing Home 5		jury occurre	Other:	·
ion (tending eath. tor: Af	ţį	1 X Natural 5 Pending	(Month, Day, Ye	ar)			1 Y	es 2 No	:				
Division of Vital Records, pital or Attending Physician: The law require corraster death.	ertification	2 Accident Investiga 3 Suicide 6 Could no	ot be 28e. Place of Inj	ury - At ho	ome, farm, stree	t, factor	y, office bu	uilding, etc.		n (Street n, State)	and Number	r or Rura	al Route Number, City
Dispital	S	4 Homicide determine	(0,000,1)		 				<u>.J.</u>				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the bur	Medical	(Check only	cian: To the best of my er:On the basis of exam										
To To Con	Mec	29b. Signature and title of certifier	and manner stated.			29	c. License	number		29d	Date signe	d (Mont	h, Day, Year)
		Je any & Jouthe	(, M)				O.C.N	И.E.		Au	gust 11, 2	2010	
		30. Name and a few of person who				t Don-	Strant	Raltimore	MD 21201				
	240	Pamela E. Southall, MD	Assistant Medic	s Signatu	ire .	~		, palumore	e, MD 21201				
Regis	tate	31. Date filed (Month, 46 Yar)	2010 32. Rigistran		A ha	de							

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ July 31 2010 Edward Hewlett, Sr. 21:20 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert Prince Frederick Calvert Memorial Hospital If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗗 M 2 🗆 F Months Hours 0371671950 Washington, DC Director 60 **216-58-52**05 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Calvert Lusby 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 403 Clubhouse Drive #18 20657 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Yes 2 X No ð 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Completed 3 Divorced 4 Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 12 truck driver supply company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Winslow Hewlett Mary Catherine Fisher Robert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 403 Clubhouse Drive, #18, Lusby, MD Paula Hewlett, wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 😾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Metropolitan Crematory 08/03/10 Alexandria, VA 22. Name and Address of Facility Rausch Funeral Home, P.A. Sometime of Funeral Service Lice 8325 Mt. Harmony Lane, Owings, MD sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ure. List only one cause on each line. Part 1. Enter the o shock, or heart fai Interval Between Onset and Death Immediate Cause Nipal Physician/ 0 ronaro disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami attending physician and for use as the burial-transit Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical ewlett, Mark Edward Sr. IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death signed by the a 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 2 No page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) Hospital Other: 2 X-NO မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending | 24 hours after death. injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A Accident Investigation the Suicide 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a, Certifie 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one)

Registrar DHMH 17 Rev 7/2009

5

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Charles W. Bennett,

AUG

ances a . De netter

MD

32. Registrars Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License numbe

D25156

Sparker

11845 H.G. Trueman Road, Lusby, Maryland 20657

29d. Date signed (Month, Day, Year)

August 2, 2010

			For State	State of Ma		/ Depa	artmer		lealth and N	Mental Hy	giene	2010	25655	
	Physicia	n/	Registrar 1. Decedent's Name (First, Middle, Las	st)		Cer	uncai	e oi L	realii	2. Date of Dea	Reg. No. ath Day	v Year	3. Time of Death	
	Medic	al	LORENE M HALI 4a. Facility Name (if not institution, give				4b City	AATT 3C			30	2010 County of Dea	12:34 PM	
, ,	Examin	er		RIAL HOSP	TTAT.		4b. City, Town, or Location of Death FREDERICK				FREDERI			
ı	Funeral Director		5. Social Security Number 6. S 537-14-6720		In yrs. last	birthday) Yrs.	If Unde Months	Pr 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da Sept. 7	h y, Year) 19:	Co	rthplace (State or Foreign ountry) SCONSIN	
	ihow at	ا د	Usual Residence of Decedent 10a. State 10b. County		10c. City, T	Town or Loc	cation						10d. Inside City Limits	
	Maryle 28a-f s otified	Director	Maryland Freder	rick	Frede	erick							1 ☐ Yes 2X No	
	th the								P P			g. Citizen of What Country?		
	eath wi		8821 Indian Spring	12. Was Decedent Eve	er in U.S.	13. V	Vas Dece	217 dent of His	spanic Origin? (Sp	ecify Yes or No-		nited S 14. Race - Ame		
Maryland 21215-0036	irs after de ural", or it I Examine	Completed by F	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates.	0	- 1		-	n, Mexican, Puerto Specify:	Rican, etc.)		Black, Whit	te, etc. hite	
15-0	72 hou "natu ledica	plet	15. Decedent's E (Specify only highest gro			16a. Deced		rk done d	ation uring most of work	king	16b. Ki	ind of Business	Industry	
212	within giene. er thar the M		Elementary/Seconday (0-12)	College (1-4 or 5+)	'	iiie. DC		e reurea) emake	r			Own Hom	ıe	
nd	filed v d othe event,		17. Father's Name (First, Middle, Last)						18. Mother's Nam	ne (First, Middle,	Maiden S	Surname)		
ryla	should be file hand Mental I 7 is marked o raumatic eve	욘	Otto M. Negard 19a. Informant's Name/Relationship (7)	in a Drivet	—-т				Lily An			T 0111 7	:- O(1)	
Ma	1 and 2 f Healtl item 2 other 1		Loretta Sienkiewic					nd Number or Rur prings R				yland 21702_		
Baltimore,			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐		20b. Plac	ce of Dispos	sition (Na	me of		Date		ocation - City or		
ţ	t. Page tment o rtant: If ijury or		4 Donation 5 Other (Specia	(y)	Fore				ry 8/7/				South Carolin	
Bal	permit Depar Impor any in once.		21. Signature of Fineral Service Licens	Minun			Namea taufi 521 (er F Doss	uneral He umtown P	omes P.	A.	ick.Mar	yland 21702	
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only o	plications that caused to ne cause on each line.	he death. I								Approximate Interval Between	
	hysician/		Immediate Cause (Final disease or condition resulting in death)	a	De.	spr	net	on	Jan	luce			Onset and Death 3-4 Oigs	
4	Medical Examiner		resulting in death)	Due to (or as a o	1111	nce of): Gun	on i	. /	,				3-4 DAGS	
	_	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a		D-011	- , [-						30, /-	
	be executed sician and burial-transit	Examiner	Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to (or as a	consequer	nce of):								
0	physician the burial	ल	L	l d										
876	tificate ng phy as the	Med	IF FEMALE:								Т			
Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Luneral Director: After this certificate has been signed by the attending physicic completed filled in by the funeral director, page 2 should be detached for use as the but	Completed by Physician/Medic	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at t 9 Unknown	Fetal d	leath 3 🗌	Ectopic Other (s		у			23d. Date of de Month	elivery Day Year	
P.0	requires that the dea been signed by the a should be detached	y Ph	Part II. Other significant conditions of	_	not result	ing in the u	nderlying	cause giv	en in Part I.	23e. Did to	obacco use contribute to the cause of death?			
ds,	equires sen sig ould b	ted I	AENAL FA	illist						1 🗆	Yes 2		Probably 4 🗌 Unknown	
Recol	The law re ate has be page 2 sh	Comple								24a. Was autoj perfo 1 🗌 Yes	osy ormed?	prior to death?	utopsy findings available completion of cause of s	
ital	ician: certific rector,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:				Loui	ace of Death (Chec					
of V	g Phys er this eral di	e: Tc	27. Manner of Death	1 Inpatien 28a. Date of injury (Month, Day,	28	R/Outpatien Bb. Time of injury		28c. Injury	4 □ Nursing H	ome 5 Residence 128d. Describe h			cify)	
lon	eath. or: Aft	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be			М		Yes 2 No						
Divis	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 v.		4 Homicide determined	building, etc.	(Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	Hosp 24 ho Fune leted fi	Medical	(Check 2 Medical Exam	sician: To the best of m iner: On the basis of exa se Practioner : To the be	mination a	nd/or invest	tigation, in	my opinio	n, death occurred a	at the time, date a	and place,	, and due to the	cause(s) and manner stated.	
	To the within To the comp	2	29b. Signature and title of certifier	1111		h	29	c. License			29d. Dat	te signed (Mont	th, Day, Year)	
	•		30. Name and address of person who	completed cause of dea	ath (Item 2	3a) (Type, P	Print)	<i>O</i> .	(//					
	10		Ronald Miller MD.	#4 Culwel	1 Dri	lve, M	1t. A	iry,	Marylan	d 21771				
	Sta Registr	te ar	31. Date filed (Month, Day Year)	32. Registrar	s Signatur	ø.	100	Ked						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year 1:10 29 2010 **Physician** Jul_v Ε. Halloran Charles /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Sandy Spring Brooke Grove Nursing Home Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6 500 Hours Days **Funeral** Washington, D.C. 1926 1 X M 2 □ F Oct. 83 578-38-4585 Director Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be processed. 10c. City, Town or Location 10b. County 10a State 1 ☐Yes 2 ☐No 01ney Director Md. Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20832 3721 Queen Mary Drive Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S.
Armed Forces?
1 ⊠Yes 2 □ No 1943 −
If Yes, Give
Year or Dates: 1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 🖾 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Automotive Auto Dealer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Doherty Beatrice Halloran, Sr. Ε. Charles 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3721 Queen Mary Drive, Olney, Md. Kimberly S. H. Lewis/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Alexandria, Va. 7/29/10 Metropolitan Crem. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Muriel H. Barber Funeral Home 21. Sign. r - of Fure al Servi e Livens Box 5038, Laytonsville, Md. 20882 tolle m-00470 P. O. 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death HOURS SEPSIS Immediate Cause (Final **Physician** disea e or condition resulting in death) Due to (or as a consequence of): /Medical 3 months Examiner SACRAL DECUISITUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed and burial-tran Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) 4 ☐ Pregnant at time of death 9 ☐ Unknown ned by the a detached for P.O. 9 Unknown s been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Chrome autopsy has performed 2 🗆 No page 1 ☐ Yes 2 No 1 TYes certificate 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 은 this 28d. Describe how injury occurred After this 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b Time of 27. Manner of Death Certification: 1 Natural Division Hospital or Attending 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the I within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYCAND. (TED E. HOWE, MD WILLAMSPORT ST. 154 N. ARTIZAN 15+1UA 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Cardenas.

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death MOHES 11:10 P Physician/ AVGUST 2019 Medical cility Name (if not institution, give street and number) 4b. City, Town, or Location 4c. County of Death Examiner Wedica 011 Baltimore Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ 1 1 2 - 1 9 3 4 Country) Delaware 75 221-22-6110 Director Usual Residence of Decedent 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Tes 2 No Kent Dover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19901 USA 89 Lebanon Road Page 1 and 2 should be filed within 72 hours after death v ment of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 Pyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural", Specify: White Completed 3 Widowed 4 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ed other than " Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Mechanic Automobile Be 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic even once. 17. Father's Name (First, Middle, Last) ၉ Mary Emily Saxton Herbert E. Hughes, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $89\ Lebanon\ Rd., Dover,\ DE\ 19901$ 19a. Informant's Name/Relationship (Type, Print) Nancy L. Hughes/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Sharon Hills MemPk 8/6/2010 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dover, Delaware 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Pippin Funeral Home, nature of Funeral Service Licenses 119 W. Cam-Wyo Ave.Wyoming, DE 19934 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of burial-transit or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physician should be detached for use as the buria Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) 1 Yes 2 L 9 Unknown 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 \square Yes 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsv this certificate has page 2 performe 1 Yes 2 No Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Hospital Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Natural 5 Pending 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical

To the Funeral Director: After this certific completed filled in by the funeral director, 24 hours within 2 To the I

Registrar

29a Certifier

29b. Signature and title of certifier

DHMH 17 Rev 7/2009

(Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in the opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No Certificate of Death 1 - State Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month <u>20</u>10 9:15 John Louis Hedeman July Physician/ Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Wicomico Examiner Salisbury Peninsula Regional Medical Center 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Nov. 7 (In yrs. last birthday) Social Security Number Funeral Maryland 1 X M 2 A F 88 561-24-7486 Yrs Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h County 10a. State death with the Maryland the Medical Examiner must be notified at Director Salisbury 1 Yes 2 X No Wicomico Maryland 28a-f 10g. Citizen of What Country? U.S.A. 10f. Zip Code 5 21804 943 Winding Way Road Funeral items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Black, White, etc 11 Marital Status Armed Forces?
1

Yes 2 □ No White 1 Never Married 2 K Married ō à 1 Yes 2 No Specify: 3altimore, Maryland 21215-0036 If Yes, Give 3 Widowed 4 Divorced Year or Dates. 1942-45 "natural", Completed 16b. Kind of Business Industry 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 l. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "na any injury or other traumatic event. the Mactica. life. DO NOT use retired) Internal Medicine College (1-4 or 5+) Elementary/Seconday (0-12) Doctor 18. Mother's Name (First, Middle, Maiden Surname)
Emma Elizabeth Koppelman Be 17. Father's Name (First, Middle, Last) Walter Rider Hedeman 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1200 River Bay Road Annapolis, Maryland 19a. Informant's Name/Relationship (Type, Print) 21409 Joanne Couser/daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Maryland Vets. Cemetery 8/4/2010 Crownsville, Maryland crematory or other place 1 Denoval from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Sig of F neral Service Licensee 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Ischemic Cardiomyopathy Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Small Bowel Obstruction Sequentially list conditions, bue to for as a consequence of Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Metabolic Acidosis or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Year in the past 12 months? Pregnant at time of death signed by the at Id be detached for 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Nown Completed Were autopsy findings available prior to completion of cause of death? peen 24a. Was an autopsy has perform page 2 Yes 2XXV this certificate 26. Place of Death (Check only one) 25. Was case referred to medica funeral director, Be examiner? Other: Hospital 4 Nursing Home 5 Residence 6 Other (Specify) 1XXInpatient 2 ER/Outpatient 3 DOA 2XXNc ၉ 28d. Describe how injury occurred 28h Time of 28c. Injury at 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: work? 1 ☐ Yes 2 ☐ No After 1 X Natural 5 Pending M within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu Investigation Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 4 Homicide determined TEXCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Hospital Medical 29a. Certifier (Check 3 only one) 29d. Date signed (Month, Day, Yes July 29, 2010 29c. License number 29b. Signature and title of certifier D54127

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

AUG 0 2 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Alon Davis, MD 100 Power Street Salisbury, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 25659 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2335 Physician/ JUIL 2010 DONALD ALDRIDGE HORNEY, SR. Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Easton talbot Hospital Memorial 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** oct. 13, 1937 MARYLAND Months Days Hours Min. 1 X M 2 🗆 F Yrs 72 218-34-3162 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State iral", or items 23a or 28a-f sho Examiner must be notified at with the Maryland Director 1X Yes 2 ☐ No QUEENSTOWN QUEEN ANNE'S MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral <u> 21658</u> 111 CHARITY LANE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married <u>S</u> Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. College (1-4 or 5+) Elementary/Seconday (0-12) AUTOMOTIVE -0--**MECHANIC** 12 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) 2 SADIE MAE THOMAS HAROLD ALDRIDGE HORNEY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 111 CHARITY LANE, QUEENSTOWN, MARYLAND 21658 JOSEPHINE V. HORNEY/ WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State 8-3-2010 EASTON, MARYLAND WOODLAWN MEMORIAL PARK 4 Donation 5 Other (Specify) Signat FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. CENTREVILLE, MD 21617 408 S LIRERTY ST. Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one gause on each line. Immediate Cause (Final 5 1 Physician/ brain injury Anoxic disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner arres ardiac Sequentially list conditions, if any leading to immediate Examiner Due to lor as a consequence of) cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed DEPSIS Due to (or as a consequence of): Physician/Medical Pheumonia Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Month Day in the past 12 months?
1 ☐ Yes 2 ☐ No 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed Yes 2 1 ☐ Yes 2 🗷 No within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page 26. Place of Death (Check only one) 25. Was case referred to medical B B 101. Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred iniury 1X Natural 5 \square Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 3 🗆 only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title -2010 MD D54488 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Washington St., Easton, MD 2195 Bennett Registrar's Signatur State Registrar

W

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day Year Physician MARION LEE HOWARD 2010 0824 JULY 23, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S CHEVERLY PRINCE GEORGE'S HOSPITAL CENTER If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min. Hours 1⊠M 2□ F Yrs. 90 Director 1920 224-12-0278 MAY 6, Carlton, Georgia Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 ☐ No Director DC Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code UNITED STATES 20002 216 14th PLACE NE Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: BLACK Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) FEDERAL GOVERNMENT BUTCHER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ DANIEL HOWARD ZATIE EDWARDS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2405 WHITEHALL STREET SUITLAND, MARYLAND 20746 CAROLYN WATSON / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/29/ 2010 SUITLAND, MARYLAND WASHINGTON NATIONAL 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityPope Funeral Homes, P.A. m00981 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part1. Enter the disease, or com/lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart fallure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL INFARCTION **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autoosy perform 2**X** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3□ DOA Certification: To this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of pers State 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

AUG 0 2 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 25661 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 Physician/ Month Hillebrecht Marie 7:30 P M Susan August 4 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death WMHS - Frostburg Nursing & Rehab Ctr Allegany Frostburg 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Birthpiec Country) MD **Funeral** 1 M 2 D Months Days Hours Min Nov 18 Director 219-54-1505 60 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if file 27 is marked outher than "natural", or items 23a or 28a-f shown any injury or other traumating account. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Cumberland Allegany 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21502 1019 Myrtle Street USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces þ Black White etc. ☐ Yes 2 ☐ No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify. 3 Widowed 4 XDivorced Completed white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary Agnes (Meek) Laing Charles Laing 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 1033 Weires Avenue LaVale MD 21502 Brian Kunis son 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) Sunset Memorial Park 1 X Burial 2 Cremation 3 Removal from State 8/9/2010 MD Cumberland 4 Donation 5 Other (Specify) Signature Funeral Set 22. Name and Address of Facility and Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1 Approximate Interval Between shock, or heart failure. List only one cause on e ch line Onset and eath Immediate Cause (Final Onset and Ph sician/ disease or condition resulting in death) 121 Medical Due to (or as a consequence of) Examiner Jequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month ☐ Pregnant at time of death☐ Unknown 5 Other (specify) Day Year been signed by the should be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 📈 No 24a, Was an certificate has b irector, page 2 sh autopsy performe 2 💢 No 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) 2**X** No Other: ၉ 1 🗌 Yes 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ER/Outpatient 3 DOA 1 Inpatient 2 I After this Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide injury 5 Pending Investigation within 24 hours after deating the Funeral Directors completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Dav. Year) noneothylu MD 00055325 2010

DHMH 17 Rev 7/2009

7

State Registrar В

e walsh

Cumberland MD2/502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrars

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 27 2010 Year Celeste Evelyn Hildebrand A M 9:15 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Braddock Hgts. Vindobona Nursing Home Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 M 2 XF Days 215-42-3410 Months 95 MD (Ountry) Director Usual Residence of Decedent 28a-f shov 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Frederick Middletown 1X Yes 2 ☐ No 10e. Street and Number ö 10f. Zip Code 10g, Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Oppartment of Health and Mertal Hygiene. Important: I firem 27 is marked other than "natural", or items 23a or any injury or other tranmatic event, the Medical Examiner must be, any injury or other traumatic event, the Medical Examiner must be. Funeral 21769 117 Prospect St. USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) retail sales dept store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Surname) ည Ruth Evelyn Pfeifer Roy E. Everhart 19a. Informant's Name/Relationship (Type, Print)
Lois Shank (Daughter) 19b Mailing Address (Street and Aumber or Rusal Route Aumber, City or Town Milete, Zor 769 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1 X Burial P ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lutheran cemetery 8/2/2010 Middletown, MD ^{22. Na}Donard de Bacility Thompson Funeral H POB 18, Middletown, MD 21769 Part 1. Enter the disease, or complic shock, or heart failure. List only one s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e on each line. Approximate Interval Betweer Immediate Cause (Final Physician/ Onset and Death Dementia disease or condition ROCK Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to forms a consequence of: tany leading to in medial cause. Enter Underlying Cause (Disease or linjury that initiated events and -transit resulting in death) Last Due to (or as a consequence of): burial physician s the burial Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Pregnant at time of death Day Year a 🗌 IJnknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by the Hospital or Attending Physician; The law requires 1 \square Yes 2 \square No 3 \square Probably 4 \square Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner? within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Watural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 2 Accident work?
1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I only one)

State Registrar ath

610

Brunsweller

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Harvey 00:36 David Paul 26 2010 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** The Johns Hopkins Hospital **Baltimore City** Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 🔀 M 2 🗆 F Jan 29, Maryland 1949 61 220-50-2044 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ¥ Yes 2 ☐ No Director MD Carroll Lineboro 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number ō USA 23a 21102 4323 Main St. Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 1968 2 No ō 1 ☐ Yes 2 XNo Specify: Specify: þ 3 Widowed 4 Divorced 1972 White "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Carroll Hospital Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other than Center Plant Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edna Leona Lowe Paul Ingram Harvey ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once. 4323 Main St. Lineboro, MD 21102 Dora C. Harvey 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State 7/29/10 Finksburg, Maryland Evergreen Mem. Gardens 4 Donation 5 Other (Specify) re of Funeral Service Lic 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA Westminster, MD 412 Washington Rd. 23a. Part Enter the disease, or commiscations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Immediate Cause (Final SEPSIS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) and Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23h Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death
9 Unknown 5 Other (specify) 2 🗌 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. þ 2 No 3 □ Probably 4 □ Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 🗌 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA ၉

Division of Vital Records, P.O. Box 68760. or Attending Physician: The law requires that the death certificate be

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) 5 Pending investigation 1 Tes 2 No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only

To the Hospital or within 24 hours after death.

To the Funeral Director: After this ormoletely filled in by the funeral dir WIL 10 TIVA 42

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rea Vate

600 North Wolfe St, Baltimore, MD, 21287

29d. Date signed (Month, Day, Year)

2010

State Registrar one)

29b. Signature and title of certifier

32. Registrar's Signature

29c. License number

RES 000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For AMEND#1 per Phy State of Maryland State of Maryland HEALTH DEPT. CMH State of Maryland / Department of Health and Mental Hygiene 25664 Reg. N 2 0 Certificate of Death Tuovi H. Hemdal 2. Date of Death Physician/ 30AM Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Ellicott City Health & Rehab Ellicott City Howard 8. Date of Birth 9. Birthplace (S Aug. 27, 1938 Fin Land 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 Director 219-25-5667 Usual Residence of Decedent show 10a. State or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location Director 1 🗌 Yes 2 🏝 No MD Anne Arundel Crofton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2360 Putnam Lane 21114 Finland 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married ģ Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatin seconds. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Vilho Karhu Siiri Jarva 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Goran Hemdal / Spouse 2360 Putnam Lane, Crofton, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 🔲 Burial 2XX Cremation 3 🗌 Removal from State Metro Crematory 7/29/2010 Baltimore, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 23a. Part 1. Enter the disease, or complications that caused shock of heart failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death CARDIOPULMONARY ARREST Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence or). DEMENTIA Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transil that initiated events Due to (or as a consequence of): resulting in death) Last DYSUPIDEMIA Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) Month Dav Year 1 Yes 2 L 9 Unknown s been signed by the same should be detached Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 1 Ho 3 Probably 4 Vnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed' certificate 1 🗆 Yes 2 🗆 No 25. Was case referred to medical examiner? completed filled in by the funeral director, Be 26. Place of Death (Check only one) 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Tes 2 No hours after death 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and tille of certifie KRTIK J. DETAL M29C. License number PHPSICIAN ss of person who completed cause of death (Item 23a) (Type, Print) 30. Name and add Ridge 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year Month 14:05 PM 2010 Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Calvert Memorial Hospital Calvert Prince Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 5 Months Days Min Country October 5. Director Yrs 1915 578-28-9805 94 Usual Residence of Decedent show 10a. State 10b. County the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 Tes 2 No MD Calvert Chesapeake Beach 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r Funeral 6536 9th Street 20732 USA death v items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Black, White, etc. ò þ 1 Never Married 2 Married within 72 hours after Maryland 21215-0036 1 ☐ Yes 2. No Specify. "natural", 3 Nidowed 4 ☐ Divorced Specify Completed Black Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+ the th Housekeeper Federal Government Be filed Department of Health and Mental Hip Department of Health and Mental Himportant If Item 27 is marked oth any injury or other traumant. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Maurice Sewell Brooks, Sr. Agnes Jane Coates 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, P.O. Box 1849, Prince Frederick, MD 20678 Marsha M. Plater - Niece Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1

■ Burial 2

□ Cremation 3

□ Removal from State cemetery, crematory or other place)
Lincoln Memorial Cemetery August 7, 2010 Suitland, MD 4 Donation 5 Other (Specify) Sewell Funeral Home, P.A. 21. Signature of Funeral Service Licens 22. Name and Address of Facility 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consi Examiner Sequentially list conditions cause. Enter Underlying
Cause (Disease or iinjury Exami Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as physician at the burial-Physician/Medical Box 68760 signed by the attending plant be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year 9 Unknown P.O. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy page perform certificate Yes 2 No Division of Vital ector, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Tes Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred nin 24 hours after death.

the Funeral Director: After appleted filled in by the funeral 1 Natural 5 Pending Accident 1 🗌 Yes 2 🗌 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🖺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

5

29b. Signature and title of certifier

30. Name and

John 31. Date filed (Month, Day oleted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25666 Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year JOSEPHINE JOHNSTON Medical ROCE LIGUST 6.35 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FREDERICK

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Pay, 1)

Aug. 92, 1 FREDERICK MEMORIAL HOSPITAL FREDERICK 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🏝 F 83 **Director** 038-12-4471 ~1926 Rhode Island Usual Residence of Decedent or 28a-f show notified at filed within 72 hours after death with the Maryland 10a State 10b. County 10c, City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No Maryland Frederick Mt. Airv ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be Funeral 6813 Woodville Road 21771 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ğ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 5+ <u>Senior Scientist</u> N.A.S.A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be file ment of Health and Mental I ant: If item 27 is marked o 2 Robert Forte Rose Varca 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kevin Johnston/ Son 6813 Woodville Road, Mt. Airy, Maryland 21771 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date 20c. Location - City or Town, State ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Stauffer Crematory Inc.8/2/2010 Frederick, Maryland 21. Signature Juneral Seg 22. Name and Address of Facility Stauffer Funeral 1621 Opossumtown Homes Pike, P. A. Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sepsi Enysician disease or condition resulting in death) Medical Due to (or Examiner 1204 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 1 ☐ Yes 2 🕱 No Month Year Pregnant at time of death Dav ed by the a detached f 9 Unknown 9 Unknown nas been signed by 9 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed?

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 certificate After this To the Funeral Director: completed filled in by the

Be

ဥ

Accident
Suicide

31. Date filed (Month, Day

Investigation

determined

6 Could not be

1 ☐ Yes 2 ☐ No Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 X No Other: 1 Tyes 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No ▼ Natural 5 Pending injury

Certificate: 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifie (Check

28e. Place of Injury - At home, farm, street, factory, office

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29c. License number 29d. Data signed (Month, Day, Year) 8 D0063256

MO

Ramani 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KAMANI NOKKU Frederick. 400 W

32. Regist ar's Signature

State Registrar

4

e Funeral

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene Registrar DOR/8/4/10/LDB

Certificate of Doorth 25667 Reg. No 20 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year 30, James 6:50A 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 40 0/0 aroline Denton Koac burg 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 102 M 2□ F Months Days Hours Min. 214-60-Director 28 Yir9 nia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite Modical Experiment ust he reserved. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No era 10e Street and Number 10f. Zip Cod 10g. Citizen of What Country? 21632 U S by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 __Yes _ 2 __No 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Baltimore, Maryland 21215-0036 🅖 1 Never Married 2 Married 1 Yes 2 1 If Yes, Give Year or Dates: 1 □ Yes 2 12 No Specify. 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Sycondary (0-12) College (1-4or 5+) raving Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname; ပ Baines 19a. Informant's Name Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denten Mary Jand 21629

20c. Location - City of Town, State Greensboro Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 8 4 ☐ Donation 5 ☐ Other (Specify) 7/10 ng Grove Cemetery Denton, Marylana 22. Name and Address Facility 21. Signature of Funeral Service Licensee Funeral Home, Henry Funeral Siowashington MD.216L StrC 23a. Part f. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CSHUC it mos /Medical Due to (or a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and burial-trar (r as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death ☐Yes 2☐No 5 Other (specify) the detached 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No. 24a. Was an page 2 autopsy perform 1 □ Yes 2 the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1∐ Yes 2)ZÍNe Other: 4 Nursing Home 5 Residence 6 Other (Specify) 은 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral (28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending n 24 hours after death.

le Funeral Director: Aft
bletely filled in by the fun 2 Accident investigation 1 Tyes 2 🗆 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29b. Signature and title of certifie 2 29c. License number 29d. Date signed (Month, Day, Year) 6388 2010 3

Registrar DHMH 17 Rev 1/2001

State

30. Name and

Colling 31. Date filed (Month, Day, Year)

4 ZUIU

address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

4U5

M.D.

Michael J. Fadden,

0-05840			pe or Print in								
awn L Jacksor		S ¹ - For State	tate of Marylan				and Men	tal Hygiene	20	10 2	5668
		Registrar 1. Decedent's Name (First, Midd	flo Lost)	Cert	ificate o	Deam		2. Date of D	Reg. No.	2 Tim	e of Death
Physici Pedical Exami		Dawn	Louise		Jackso			Month August	Day Yea 4, 2010	ar 190	04 hrs
		4a. Facility Name (if not institution Western Maryland He		ber)		4b. City, Town, Cumberla		of Death	4c. County Allegan		
Funeral Director		5. Social Security Number 212-84-8180		Age (In yrs. las			ear If Under ays Hours	1.00-	Birth(MM/DD/YYY) 6, 1960	9. Birthplace Foreign Country	
	P	Usual Residence of Decedent	1 M 2 7 F	49	Yr	s		11104	0, 1300	Codini	
any		10a. State 10b. County		10c. City, T	own or Loca	tion					nside City Limits
daryland 28a-f show 1 at once.	Ŀ	MD A	llegany		Cur	nberland	b			1 🗶	Yes 2 No
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland fealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 12516 Blue \	/alley Road			10f. Zip Code	215	502	10g. Citizen of W	hat Country? USA	
n with ms 23s		11. Marital Status		lent Ever in U.S				gin? (Specify Yes or Puerto Rican, etc.)		e - American Indi	ian, Black,
ter deatl	Funeral	1 Never Married 2 N 3 Widowed 4 Div	1 Yes	2 X No	1 "	Yes 2X		, r derio (ricari, etc.)		white	
ours af atural camin	d by	15. Decedent's Education (Spe	l or Dates: ecify only highest grade	completed)		nt's Usual Occu		kind of work done		usiness/Industry	
36 hin 72 h edical E	ompleted	Elementary/Secondary (0-12)	College (1-4	or 5+)		al assist		use retired)	dentis	strv	
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	ပ	17. Father's Name (First, Middle	e, Last)		GOTTE	<u> </u>		's Name (First, Middle			
21215-00% hald be filed with Mental Hygiene, marked other ti	o Be	Lonnie R.			1 10h Mailie	Addross (St		oyce (Joh			de)
imore, MD 21215-0036 Pages I and 2 should be filed within 72 ment of Health and Mental Hygiene. tant: If item 27 is marked other than or other traumatic event, the Medical	ř	19a. Informant's Name/Relations Kyle Whetse	h	usband	12	516 Blu	ie Valle	ey Road C	cumberlan	d MC	21502
Baltimore, MD permit. Pages I and 2 sh Department of Health and Important: If item 27 is injury or other traumat		20a. Method of Disposition 1 Burial 2 Cremation	n 3 Removal from		ace of Dispo ematory or o	sition (Name of ther place)	cemetery,	Date		- City or Town, S	State
Fage ment crant:		4 Donation 5 Other S	pecify:	Scar		neral Hom		8/6/2010	Cresa	aptown	MD
Baltimore, MI permit. Pages I and 2 s Department of Health a Important: If item 27 injury or other traum.		21. Signature of Funeral Service	e Licensee		22.1		pelli Fun	eral Home, PA		1500	
Physician		23a. Part I. Enter the disease, or failure. List only one cause	r complications that caus	sed the death. [Oo not enter	the mode of dyir	ng, such as ca	Avenue: Cumb ardiac or respiratory	arrest, shock, or he	art Appro	oximate Interval
/Medical Examiner	3 (9	Immediate Cause (Final disease	a. Multiple Injuri								Death
		or condition resulting in death)	Due to (or as a co	onsequence of):							
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a co	onsequence of):							
- lo	Examin	(Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence of):							
nn and L-transi	calE		d								
O, e be ex ysician burial	edic	UNPENDED	AMENDED						lood Bata of		
ox 68760, eath certificate be executed attending physician and or use as the burial - transi	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		tcome of pregna n		etal death	3 Ectopic	pregnancy	23d. Date of Month	Day	Year
OX 6 leath ce	Physician/Medi		4 Pregnan	t at time of deat	th 5 0	ther (Specify)					
S, P.O. Bc	1	Part II. Other significant condi		eath but not res	ulting in the	underlying caus	e given in Pa	rt I. 23e. Did	d tobacco use contr	ibute to the caus	se of death?
s, P. nires thr signed d be de	d be								res 2 ✔ No 3		
of Vital Records, ing Physician: The law required Physician: The law required this certificate has been sureral director, page 2 should	Completed								topsy	Were autopsy fir prior to completion	
Rec The la	- E			_					formed? s 2 ✓ No 1	death? Yes	2 No
ital ician: s certif rector,	Be	25. Was case referred to medica examiner?		atient 2 🗸 E	:P/Outpation		Other	(Check only one) Nursing Home 5	Residence 6	Other:	
n of V ling Phys After thi funeral di	5	1 Yes 2 No 27. Manner of Death	2Ba. Date of	Injury 2	28b. Time of		njury at Work	? 2Bd. Describ	e how injury occurr	red	
ion (tending eath.	ation	1 Natural 5 Pen-	ding Aug 4, 201	av Year)	1812 hrs	1	Yes 2♥	No tree fell or	n subject while	riding a bike	Э
ivisi lor Att after da Direct	ertification:	3 Suicide 6 Cou	ld not be 2Be. Place of		ne, farm, stre	et, factory, office	e building, etc	or Town	n (Street and Number, State)		
Divi	ပ	29a, Certifier	rmined (Specify) t	1.50	doath occu	rod at the time	data and pla		ail near Valley St		land, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buring	Medical	(Check only Certifying F	hysician: To the best o aminer: On the basis of e and manner state	examination and							(s)
F . 2 5	Re	29b. Signature and title of certific					nse number			ed (Month, Day	, Year)
		(all	W		77	0.0	C.M.E.		August 5, 2	2010	
12		30. Name and address of person Zabiullah Ali, M.D.		1		n Street, Ba	altimore, M	/ID 21201			

DHMH 17 Rev 1/2001 OCME 2006

State 31. Date filed (Month, Day, Year)
Registrar AUG 1 7 2010

32. Registraric Signature

state of Maryland Department of Health and Merital Agriche 20 10 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Naomi J. Jones 2010 1:35 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 410 E. D Street Frederick Brunswick Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF Months Hours Min. Sept. 10 Kentucky Director 85 1924 236-32-2401 Usual Residence of Decedent 28a-f show artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shoi injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No Maryland Frederick Brunswick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 410 E. D Street 21716 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes X No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes X No Specify: If Yes, Give Year or Dates 3 XWidowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other this any injury or other transmission. 11 Waitress Food Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Nora Duncan Robert Enos Tracy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8514 Barnes Rd., Boonsboro, MD 21713 Donna Jones / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 7/31/2010 Frederick, Maryland Resthaven 21. Sign we of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Rome 1100 N. Maple Ave., Brunswick, MD 21716 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on or ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final small cell long cancer Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examine Due to (or as a consequence of) Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, cate has been sig page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director; g 25. Was case referred to medica å 26. Place of Death (Check only one) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00067691 7-28-10 who completed cause of death (Item 23a) (Type, Print)
ein 501 W. Seventh st. Frederick, Md 21701 Mark Goldstein

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

32. Registrar's Signature (Freezes

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month ILLIAN JOHNSON 014-AUGUST 01 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMBRE BoxView LISDICAL JOHNS HOPKINS None COLOR If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days 1 ☐ M 2 🕱 F Hours 78 12/19/1931 212-28-5786 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD 1 ☐ Yes 2 N No Howard Ellicott City 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21043 2837 Southview Road United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 □XNo Specify Specify: White 3K Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Raymond J. Noon, Sr. Lillian E. Durkin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Anita Crosman - daughter 105 Pheasant Run Lane Hanover, PA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cem. 08/05/2010 Baltimore, MD 21. Signature of Funeral Service Licensee MO1044 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HYPERCARSIC ESPIRATURY Due to (or as a consequence of) Vocume Chamas Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off. NON-12CHEMIC CARDIOLINOPATA Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 💆 No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4,K Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performer 1 □ Yes 2 No 1 ☐ Yes 2 □ No 26. Place of Death (Check only one) Hospital: 12 Inpatient 2 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending

/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely lifted in by the funeral director, page 2 should be detached for use as the burial-transit P.O. Box 68760. Division of Vital Records,

Physician

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

ပ္

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" any injury or other traumatic everage.

Examiner edical Medical Certifica

4 Homicide

(Check only one)

29b. Signature and title of certifier

	1.5
	tion: To Be Completed by Physician/N
	T = 1
	1.5
	(1)
	I .= I
	40
	(0)
	-
	I D. I
	-
	122
	- 73
	a do
	12
	1 75 1
	100
,	1 5 1
	1 7 1
	101
	40
	- Ψ -
	- m
	1 444 1
	1 1
	1 4 4 1
	_
	-

State Registrar

25. Was case referred to medical examiner? 1 Yes 2√2 No 27. Manner of Death 1 Natural 2 Accident investigation 3 ☐ Suicide

6 Could not be

determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 154 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year) AUGUST 01,2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ItI Bayview CHEISPIN JONATHAN

32. Registrar's Signature,

Aredical Center

1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Honth ZOIC 9800AM L. Koehler Honoria Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Doctors Community Hospital Lanham Prince Georges 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 Months Days Hours Sept. 17, 1917 Director Ireland 215-46-4131 92 Usual Residence of Decedent shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f 1 X Yes 2 ☐ No Maryland Prince Georges New Carrollton 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral items 23a 6216 85th Place 20784 U.S.A. 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. , o 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0030 permit. Page 1 and 2 should be filed within 72 hours aft. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exa If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White 3 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Page Coutny Library Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carl J. Koehler (Husband) 6216 85th Place New Carrollton, MD 20784 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 8/3/2010 Chesapeake Crematory Beltsville, MD 21. Signature J Fymeral Service Licensee 22. Name and Address of Facility Rendon/Hale Funeral Home w 9013 Annapolis Rd. Lanham, MD 20706 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, effect, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Preumonia Medical resulting in death) to (or as a consequence of) _ Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): PARKINSON'S Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. the burial-transi Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 4 Pregnant at time of death
9 Unknown 5 Other (specify) Dav Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autops, performed r Ves 2 No 1 ☐ Yes 2 ☐ No I ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 인 1 🗌 Yes 2 🔀 No Other: 1 💢 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at : After i 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) Andella mi) 03 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , MD 12200 Annapoliskd, Suite 229, Glenn Dale, mb. 20169 Mukemil

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

AUG 0 4 2010

Physi /Med Exam

Funera Directo

Regis DHMH 17 Rev 1/2001

	Please Type or Print in Bia		artment of Health and I		•							
	1- State of Maryland 7	8 e	dificate of Death	Reg.	2010	25672						
cian	1. Decedent's Name (First, Middle, Last)			Date of Death Month	Day Year	3. Time of Death						
lical	Kenneth T. King			July 27,		12:00A M						
iner	4a. Facility Name (If not institution, give street and number) Lorien Mount Airy		4b. City, Town, or Location of Death)	4c. County of Dea	tn						
	5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday)	Mount Airy If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	Carroll 9. Bir	thplace (State or Foreign						
r	579-22-5296	Yrs.	Months Days Hours Min.	Feb. 20,	1922 Ma	ryland						
	Usual Residence of Decedent											
5	10a. State 10b. County 10c. City, To	own or Lo	cation			10d. Inside City Limits 1 □ Yes 2 📉 No						
ecto	Maryland Montgomery Da 10e. Street and Number	masc	us 10f. Zip Code	100	Citizen of What Co							
Funeral Director				109.	U.S.A.							
Jera	25326 Woodfield Road 11. Marital Status 12. Was Decedent Ever in U.S.	13.		pecify Yes or No-	14. Race - Ame							
Ē	1 Never Married 2 Married	j	f Yes, specity Cuban, Mexican, Puerti 1 □ Yes 2 ၨ█No <i>Specify</i> :	o Hican, etc.)	Black, Whit	e, etc.						
Completed by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		To Tes 20 No Specify.		1	ite						
ete	15. Decedent's Education (Specify only highest grade completed)		dent's Usual Occupation kind of work done during most of work	kina i	. Kind of Business	•						
Ę	Elementary/Secondary (0-12) College (1-4or 5+)	me. r	kind of work done during most of wor. DO NOT use retired: Ufficer Colice Officiar	M	ontgomery Marylar	•						
Be Co	17. Father's Name (First, Middle, Last)			ne (First, Middle, Maid		<u> </u>						
To B	Thurston B. King		Pomo	na Burdet	te							
	19a. Informant's Name/Relationship (Type. Print) 1	9b. Mailir	ng Address (Street and Number or Ru	ıral Route Number, Ci	ty or Town, State,	Zip Code)						
	Leonard T. King, Sr Son		7 Melbourne Avenu									
	I Burial 2 Ly Cremation 3 Li Removal from State I	of Dispo etery, cren	sition (Name of natory or other place)	Date 20c	. Location - City or	Town, State						
	4□Denation 5□Other (Specify) Metr	opol:	itan Crematorium	7/28/10 A1	exandria	, Virginia						
	21. Signature of Funeral Service isensee	′ Mo	2. Name and Address of Facility 2. Lesworth-William.	s P.A., Fu	neral Ho	me						
	23a. Part 1. Enter the disease, or complications that caused the death. D	126	14UL Ridge Road.	Damageus	Marylan	1 20872 Approximate						
	shock, or heart failure. List only one cause on each line.			,,		Interval Between Onset and Death						
	Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):											
r												
ner	Sequentially list conditions, in the local section of the local section	ce of):										
Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence)											
is E	Due to (or as a consequent	be oi).										
	d											
n/Me	IF FEMALE: 23b. Was decedent pregnant				23d. Date of de	elivery						
by Physician/Medic	in the past 12 months? 1		Ectopic pregnancy Other (specify)		Month	Day Year						
hys	9 Unknown											
by	Part II. Other significant conditions contributing to death but not resulting	g in the u	nderlying cause given in Part I.			o the cause of death?						
Completed						robably 4 Unknown						
mple.				24a. Was an autopsy performed	prior to	utopsy findings available completion of cause of						
				1 □ Yes 2		s 2 (200)						
Be	25. Was case referred to medical examiner? 1 ☐ Yes 2	/Outpatier	Other	ath <i>(Check only one)</i> Iome 5 ☐ Residence	e □Othor (Co.	noife)						
n: T	27. Manner of Death 28a. Date of Injury 28	b. Time of	28c. Injury at	28d. Describe how i								
atio	2 Accident investigation	пјиту	Work? M 1 □ Yes 2 □ No									
ıţ	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	, farm, str	eet, factory, office	28f. Location (Stree City or Town, S	t and Number or Fi tate)	lural Route Number,						
2	29a. Certifier 1 Certifying Physician: To the best of my knowler	den doot	h coursed at the time, date and place		12(a) and manner of	no atatad						
(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
									30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ndrd, Feinberg 11165 Straffed Court, 1st Floor Marriotts VIIIC, MD 2116 31. Date filed (Month, Day, Year) 32. Registrar's Signature			
	30. Name and address of person who completed cause of death (Item 23	a) (Type,	Print)		0							
	Ndid, Feinberg 11165 Strath	edC	oust, 1st Floor	YarrioHsVI	11c, MD	21104						
tate trar	31. Date filed (Month, Dey, Year) 2 20 0 32. Registrar's Signature	for a	the to the									
		-	J									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. N2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ A Month Steven Lee Kendall 1109 Am Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washington County Hospital Hagerstown Washington County 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) Maryland **Funeral** Months Hours Min. Director 219-52-1403 60 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 28a-f Maryland Washington County 1 Yes 2X No Hagerstown 10e. Street and Number ö 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? Funeral 215 North Colonial Dr. 21**7**42 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Examiner ò þ 1 Never Married 2 X Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", Completed White 3 - Widowed 4 - Divorced Specify: the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) Floor Mechanic Flooring Company alth and Mental Hygie 27 is marked other r traumatic event, tt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lawrence Edward Kendall Mamie Idella Hiser Kendall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Deborah A. Kendall-wife 215 North Colonial Dr. Hagerstown, MD 21742 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 8-5-2010 Hagerstown, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home Fastern Blvd North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or c me lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Inset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) ending physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the attending IF FEMALE: 23c. If yes, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day signed by the a d be detached f 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autop... performed 1 Tyes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Tes 2 🗆 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this n 24 hours after death.

Personal Director: After the pleted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: Natural 28b. Time of 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 2 To the I 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SH-10 tretam 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens 0 | 0 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2010 Physician/ Month Stephanie Christine Kidwell July 1:50 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Country) Maryland 1 🗆 M 2 🕱 F Months Days Hours Min Director 212-82-9995 1972 Ja<u>n</u> 38 Usual Residence of Decedent show 10a. State 10b. County within 72 hours after death with the Maryland oms 23a or 28a-f short must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No Maryland Montgomery Clarksburg 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 12221 Dancrest Drive 20871 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, er than "natural", or iter the Medical Examiner Armed Forces?

1 Yes 2 No If Yes, Give Black. White, etc. δ 1 X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Widowed 4 Divorced Specify: Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be file h and Mental h ris marked ot မ John N. Kidwell permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic other traumatic Donna Asselin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John N. Kidwell - Father 12221 Dancrest Drive, Clarksburg, Maryland 20871 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) All Soul's Cemetery July 29, 2010 Germantown, Md. 21. Signat re of Fun ral Service Licensee 22. Name and Address of Facility Molesworth-Williams P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph, sician/ Respiratory Failure disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of. Exami To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 X No
9 Unknown 3 Ectopic pregnancy Dav Year 4 Pregnant : Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires to hours after death.

Funeral Director: After this certificate has been sign Spina Bifida 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Acute Renal Failure autopsy 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 유 1 Anpatient 2 ER/Outpatient 3 DOA Certificate: 28c. Injury at work?
1 ☐ Yes 2 ☐ No Division of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred injury 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

**The triving Nurse Praction or To the part of the (Check 29b. Signature an 29d. Date signed (Month, Day, Year) 30. Name and ad ress of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Atul 'Rohatgi, M.D. 8600 Old Georgetown Road, Bethesda, Maryland 32. Register's Signature

Registrar

Sidwell

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		16	1 = State Registrar	Certificate of Death	Reg. N	2010 25675
П	Physicia	n/	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	3. Time of Death
	Medic	al	Alexander Joseph Kosinski		18	1 2010 04:29 AM
	Examin	er	4a. Facility Name (if not institution, give street and number) 11 Hammer Drive	4b. City, Town, or Location of Death North East	. 4	Ic. County of Death Cecil
-	Funeral	-	5. Social Security Number 6. Sex 7. Age (In yrs. last b.		8. Date of Birth	
	Director		221-20-6949	Yrs. Months Days Hours Min.	Month, Day, Year, Dec. 10,1	g. Birthplace (State or Foreign County) Imington Delaware
	shov dat	tor	10a. State 10b. County 10c. City, To	wn or Location		10d. Inside City Limits
	Mary 28a-f otifie	irec	Maryland Cecil No	orth East		1 Yes 2 YNo
	with the s 23a or ust be n	Funeral Director	10e. Street and Number 11 Hammer Drive	10f. Zip Code 21901	"	Citizen of What Country?
	death item		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian,
9003	urs after tural", or al Exami	Completed by	1 Never Married 2 M Married 1 Never Married 3 Widowed 4 Divorced 1 Never Married 1 Never Married 1 Never Married 1 Never Married 2 Never Married 1 Never Married 1 Never Married 2 Never Married 2 Never Married 1 Never Married 2 Never Married 2 Never Married 2 Never Married 1 Never Married 2 Never Married 3 Never Marri	2 1 ☐ Yes 2 🗶 No Specify:	, (11541.1, 5151.)	Black, White, etc. Specify: White
21215-0036	iin 72 ho ie. han "nat e Medica	omple	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	 a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) 	king 16b.	Kind of Business Industry
121	d with dygier ther t	Be C		ilitary Personnel Spe		
lanc	be file lental H rked of tic ever	To B	17. Father's Name (First, Middle, Last) Alexander Kosinski		ne (First, Middle, Maide a Zarnoch	n Surname)
Maryland	12 should alth and N 27 is ma r trauma		19a. Informant's Name/Relationship (Type, Print)	Ob. Mailing Address (Street and Number or Run l Hammer Drive, North		
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State	of Disposition (Name of ery, crematory or other place) 1ale Crematory	st 7	Location - City or Town, State wark, Delaware
altii	permit. P Departm Importai any Injur		21. Signature of Funeral Service Licenses	22. Name and Address of Facility Cr		
	20 E # 9		Value Toll	127 South Main Str		East,Maryland21901
	Physician/ Medical		23a. Part 1. Enter the disease, complications that caused the death. Do shock, or heart failure. It only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence	root enter the mode of dying, such as cardiac rulive Pulmonary of:		Approximate Interval Between Onset and Death Unhnuon
	Examiner	<u>.</u>				
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	; Oij.		
	cate be executed physician and the burial-transit	Exa	that initiated events c. Due to (or as a consequence	e of):		
0948	ite be hysici ihe bu	Medical	d			
Box 687	death certifiche attending	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1			23d. Date of delivery Month Day Year
P.O.	es that the signed by t be detach	þ	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.		use contribute to the cause of death?
rds	require been si should	eted				2 No 3 Probably 4 Unknown
Division of Vital Records,	The law cate has I	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
ita	sician: The certificate rector, pag	Be	25. Was case referred to medical examiner? Hospital: Hospital: Hospital:	26. Place of Death (Chec		
of V	g Phys er this eral di	e: 10	27. Manner of Death 28a, Date of injury 28b.	Time of 28c. Injury at	ome 5 Residence 28d. Describe how inju	
on	ttending I death. ctor: After y the funer	ficat	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident Investigation	injury work? M 1 \(\sum \) Yes 2 \(\sum \) No		
Divisi	al or Atters after de al Directo	l Certificate:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	arm, street, factory, office	28f. Location (Street a City or Town, Stat	nd Number or Rural Route Number, e)
_	To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completed filled in by the fi	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge (Check 2 Medical Examiner: On the basis of examination and only one) 3 Certifying Nurse Practioner: To the best of my knowledge	or investigation, in my opinion, death occurred a	t the time, date and plac	ce, and due to the cause(s) and manner stated.
	To the within com	-				late signed (Month, Day, Year) 8. 2. 20/0.
4	STIVA		30. Name and address of person who completed cause of death (Item 23a) S.S. S. S. G. Chdew M.D., 126 A, E. H.	(Type, Print) (Type, Print) (Type, Print) (Type, Print)	21921.	
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature	9 back	-	

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

ŭ		1- For State Registrar	ato or maryia	Certif	icate of D	eath		, <u></u>	2 U I	0 23010
Physic		1. Decedent's Name (First, Middl	e,Last)					2. Date of Dea Month	Day Year	3. Time of Death
Medical Exam	iiner	Jason Eugar						August 5,	2010	1754 hrs
		4a. Facility Name (if not institution 1105 Atlantic Avenue	n, give street and nun	nber)		cean City	Location of De	atn	4c. County of D Worcester	
Funeral		Social Security Number	6. Sex 7	7. Age (In yrs, last		Under 1 Year	If Under 24h	Irs. 8. Date of Bir). Birthplace (State or
Director		210-58-9290	1XM 2 F	36		onths Days		at .		oreign Country) PA
		Usual Residence of Decedent	TAN Z		113.			Juni .		
any		10a, State 10b. County		10c. City, To	wn or Location					10d. Inside City Limits
nd show	=	MD Worce	ester	Oce.	an City					1 Yes 2 X No
daryla 28a-f 1 at ou	Director	10e. Street and Number			10	f. Zip Code		1	0g. Citizen of What	Country?
the l 3a or otified	ā	1105 Atlantic	Ave.			21842	2		US.	Α
rs after death with the Maryland ural", or items 23a or 28a-f show any miner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 X Ma		dent Ever in U.S. ces?			panic Origin? (, Mexican, Pue	Specify Yes or No rto Rican, etc.)	- 14. Race - A White, e	merican Indian, 8lack, tc.
or deal	Fu		1 Yes	2K No		_			0	1.1.
rs afte ural",	و	3 Widowed 4 Dive	orced If Yes, Give Year or Dates:	completed) 16	a. Decedent's U	sual Occupati		of work done	Specify: 16b, Kind of Busin	white ess/Industry
2 hou "nati	ompleted	Elementary/Secondary (0-12)	College (1-				DO NOT use r		100, 10,12 0, 220,	,
336 thin 7 ne. than	du		1		Cool	k			Brass Ba	lls Saloon
5-0036 led within 72 hou Hygiene. I other than "nat	ပြ	17. Father's Name (First, Middle,					8.Mother's Na	me (First, Middle, N		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Eugene Knaub						an Wolf		
Should mid M. is m.	₽	19a. Informant's Name/Relations							nber, City or Town, S	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiera. In matural", or items 23a or 28a-f she injury or other traumatte event, the Medical Examiner must be notified at once		Desislava L. Ki	naub - wif		1105 At. e of Disposition			Date Can	y , MD 218	4 Z y or Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 Burial 2 X Cremation	3 Removal from	crem	natory or other p Henlope	lace)		-9-2010	Frankfor	
ti. Partiment	9	4 Donation 5 Other Sp 21, Signature of Funeral Service		Jour	5.75-766	and Address		2 20 200	6.75	
Bal perm Depa Impo injur		AM Ina	Alan		- 1			_	uneral Ho , MD 2181	
Physician		23a. art I. Enter the disease, or	complications that cau	used the death. Do						Approximate Interval
/Medical		failure. List only one cause immediate Cause (Final disease		ioma wit	h Compl	icatio	ms			Between Onset and Death
Examiner	ı	or condition resulting in death)	Due to (or as a c		и обще	ICUCIO	ПО			
	L.	Sequentially list conditions,	b.							
	je.	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a c	onsequence or);						
sit d	Exan	(Disease or injury that initiated events resulting in death) Last	Due to (or as a c	onsequence of):						1
cecuted 1 and - transit			d	23a,27 pe		07 0 0	10			
760, cate be exophysician	Medical	X UNPENDED	<u> </u>			07 9-0	-10 VL		losts at the	
876 tificate ng phy as the	n/M	IF FEMALE: 23b. Was decedent pregnant in the		itcome of pregnand th	cy ₂∏ Fetalde	eath 3	Ectopic preg	nancy	23d. Date of del Month	overy Day Year
Box 687 death certificate attending perfections	sician/	past 12 months?		nt at time of death		(Specify)				
BO)	Phys		nown 9 Unknow					20- Did t-		- 1- 11
ires that the signed by	by F	Part II. Other significant condition	ons contributing to d	leath but not resul	ing in the under	lying cause gi	ven in Part I.			e to the cause of death? Probably 4 ✓ Unknown
rds, I requires been sig	ted							- 24a. Was a	1111	e autopsy findings available
Records, The law require ficate has been si	Completed							autop:	sy prior	to completion of cause of
tal Rec cian: The certificate ector, page	S	1							2 No 1	Yes 2 No
ician: s certif	Be	25. Was case referred to medical examiner?	Hospital:	o T ED	10. ttit 2 [- 10	of Death (Chec		Residence 6 🗸 C	Mh C
of Ving Phys After this	욘	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of		Outpatient 3		y at Work?		now injury occurred	orier. Scene
Division of Vital talor attending Physician: ts after death. al Director: After this certicle in by the funeral director	ioi	1 X Natural 5 Pendi	(Month, D	lay,Year)	, ,		es 2 No		• •	
r Atte er dea recto	ficat		tigation 28e. Place	of Injury - At home	farm, street, fac	ctory, office bu	uilding, etc.	28f. Location (S	treet and Number o	r Rural Route Number, City
Div ital or urs aft	Certification:	Juicide	mined (Specify)					or Town, S	tate)	
Hosp 24 ho Fune stely fi			ysician: To the best of							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 burus after death. To the Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical		niner:On the basis of and manner sta	examination and/o ted.	r investigation, i			at the time, date a		
	Ž	29b. Signature and title of certifier	40.0	1		29c. License		00415	29d. Date signed	
`		1	- Y	a l		O.C.N	1.∟.	OCME	August 7, 201	U
		Theodore III.	Mung TR.	, m. O						
		30. Name and address of person of the odore M. King. Ir.				Donn Str	oot Raltima	re MD 21201	1,000	200 P 22 al al 2
	tate	30. Name and address o person we have mean address of person we have mean address of person we have mean and address of person we have mean address of person we have mean address of person which we have mean address of person we have a supplied that the person we have mean address of person we have mean address of person we have mean address of person we have a supplied to the person we have mean address of person we have a supplied to the person	MD. Assistan	of death (Item 23a t Medical Examples of the Medical Examples Signature)			eet, Baltimo	ore, MD 21201		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 25677 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 Year JULY 28, Physician/ 12:10 aM GEORGIA M. LOVELACE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY MONTGOMERY GENERAL HOSPITAL OLNEY 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) Funeral Days Hours Min Months 1/5/1924 Year) GLADYS 1 M 2 F 86 VA Director 578-34-1577 Usual Residence of Deceden 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits of Health and Mental Hygiene. item 23a or 28a-f shor item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at. 10a. State Director 1 🙀 Yes 2 🗌 No MONTGOMERY BURTONVILLE MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral UNITED STATES 3242 TAPESTRY CIRCLE 20866 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Specify: BLACK 3altimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: 3 ♥ Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working (Specify only highest grade completed) life, DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) should be filed with and Mental Hygien ? is marked other the HEALTH AIDE FEDERAL GOVERNMENT llyrs Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ OCTAVIA NOWLIN RICHARD MORGAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 13013 MORNING SIDE LANE SILVER SPRING, MD 20904 FREDDIE D. LOVELACE/ SON 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State FT. LINCOLN CEMETERY 8/4/2010 BRENTWOOD MARYLAND 4 Donation 5 Other (Specify) 22. Name and Address of Facility JOHN T. RHINES FUNERAL HOME, LLC Signature of Funeral Service Licenses 3005 12th ST. NE WASHINGTON, DC 20017 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 Live Live Direction Live Birth 2 Live Birth in the past 12 months? Month Day Yes 2 No 9 Unknown 1 ☐ Yes ∠ № 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has ral director, page 2 performed 2 🗌 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital Other: 2 No ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 27. Manner of Death 28d. Describe how injury occurred 24 hours after death. Funeral Director: After injury 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide
4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge eath occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one 29c. License number 29b. Signature and

State

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year) Registrar

17904 GEORGIA

30. Name and address of person who completed cause of death (Item 23a) (Type://Print)

SUITE

OLNEY MARYLAND 30832

ATA MOTAMEDI

DR.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1- State of Maryland / Department of Health and Mental Hygiene Certificate of Death State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 0 1 0 2	5678
Physici Med			Time of Death
Exami	ner	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Chevy Chase 4c. County of Death Montgomer	`y
Funera Director		5/9-36-4460 1 M 2 LAF 83 Yrs. Molitis Days Hours Min. Jumgm, Pay, 79-3027 Washing	(State or Foreign
aryland a-f show ffied at	ector	Manuland Montgomony Chovy Chaco	nside City Limits
with the M 23a or 28 ist be noti	Funeral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20815 United States	
Ind 21215-0036 Filed within 72 hours after death with the Maryland Ital Hygiene. 3d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Never Married} \) 2 \(\text{Married} \) Married 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Inc. 15. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 16. Race - American Inc. 17. Black, White, etc.	
Maryland 21215-0036 2 should be filed within 72 hours after Ith and Mental Hygiene. 27 is marked other than "natural", o 27 traumatic event, the Medical Exam	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) ,	
Aaryland should be filed and Mental Hy is marked oth raumatic event	To Be	17. Father's Name (First, Middle, Last) Sidney Atlas 18. Mother's Name (First, Middle, Maiden Surname) Celia Kirstein	
re, Maryla 1 and 2 should be of Heath and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Print) Bruce Levenson, Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11529 Twining Lane, Potomac, MD 20854	
A	1 5	20a. Method of Disposition 1 XI Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Some of Company of Company of Company or Other place) 20c. Location - City or Town, Some of Company or Other place) 20c. Location - City or Town, Some of Company or Other place)	itate
Baltimo permit. Page Department Important: I any injury o		21. Signatur of Fred Savide Louis 401008 Porchards Kys Hellinew Funeral Home 254 Carroll St., NW, Washington, DC 200	012
Priysician/		Intendiate Cause (Final disease or condition Lung Cancer	roximate val Between tand Death
Medical Examiner		resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.	
executed an and rial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or ininjury that initiated events resulting in death) Last Cause (Disease or ininjury that one of the consequence of): Due to (or as a consequence of):	
fficate be g physicias the bu		d	
Livision of Vital Records, P.O. Box 68/60 To the Hospital or Attending Physician: The law requires that the death cartificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1	Year
dS, F.O. quires that tl en signed by uld be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause 1 Yes 2 No 3 Probably	
The law recard the law recard has been page 2 should be a should b	Completed	24a. Was an autopsy fine autopsy prior to completic death? 1 Ves 2 A No 1 Ves 2 A	on of cause of
hysician: hysician: this certifical director,	To Be	25. Was case referred to medical examiner? 1	
tending F death. tor: After i	Certificate:	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	
pital or A ours after eral Direc		4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route City or Town, State)	Number,
o the Hos ithin 24 ha o the Fun ompleted	Medical	29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day Yes)	
2		D 42051 August 2, 201	ı ı
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D. Scott Cohen, M.D., 5530 Wisconsin Ave., #930, Chevy Chase, MD 20815	
Sta Registra		31. Date filed (Month, Day, Year) AUG 03 2010 Registrar's Signature faces	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10:15 p_M Salvatore LaRussa Tulv 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 778 Dividing Creek Road Arnold Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Date of Disk. (Month, Day, Year) Ct. 04,1920 1 🛛 M 2 🗆 F Months Days Hours Min. 89 Director 121-05-7524 New York Usual Residence of Decedent "natural", or items 23a or 28a-f show idical Examiner must be notified at 10a. State 10c. City, Town or Location with the Maryland Director 10d. Inside City Limits MD Anne Arundel Arnold 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21012 778 Dividing Creek Road USA 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) vvas Decedent Ever in U.S. Armed Forces? 1 X Yes 2 D No WWII If Yes, Give Year or Dates. 14. Race - American Indian, Black, White, etc. ò 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Seconday (0-12) College (1-4 or 5+) Banker Banking 12 and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 9 Egila Lombardo Stefano LaRussa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other tratonce. 778 Dividing Creek Road Arnold, MD 21012 Lori LaRussa / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) MD Veterans Cemetery 2010 Crownsville, MD Signature de eral Service Licensee 22. Name and Address of Facility Barranco & Sons, P.A. 495 Ritchie Hwy, Severna Park Funeral Home Severna Park, MD 21146 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ankhim Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence on). Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. signed by the attending physician and dbe detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Dav Year 2 No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 Yes 2 No Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: ၉ 1 Tes 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 🗆 Yes 2 🗆 No 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital of within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif 028686 ompleted cause of death (Item 23a) (Type, Print 30. Name and addless of person v 21012 09

DHMH 17 Rev 7/2009

Registrar

Registrar's Signature

	1 - State Registrar	nd / Department of Health and Me Certificate of Death	Reg2NO 1 U 2568U
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Katie Lee 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	Date of Death Month 7 29 2010 4:18 A M 4c. County of Death
Funeral Director	249-50-7599 10M 29 -79	. last birthday) Yrs. HUNG 1 Year If Under 24 Hrs. 8 Months Days Hours Min.	Date of Birth (Month, Day, Year) 7 21 1831 CANUL XA
death with the Maryland time 23a or 28a-f show trivet be neitified at merel Director	Usual Residence of Decedent 10a. State 10b. County 10c. C 10b. Street and Number	ity, Town or Location YA +15 U - 115 10f. Zip Code	10d. Inside City Limits 1 → Yes 2 □ No 10g. Citizen of What Country?
5 E E .	11. Marital Status 15 Never Married 2 Married 12. Was Decedent Ever in the Armed Forces? 1 Yes, Give	J.S. 13. Was Decedent of Hispanic Origin? (Specifit Yes, specify Cuban, Mexican, Puerto Ric	y Yes or No- lan, etc.) 14. Race - American Indian, Black, White, etc. Specify: 1. A 1.0
Maryland 21215-0036 Id 2 should be filed within 72 hours after dea th and Mental Hygiene. 27 is marked other then "naturel; or items traumatic event, the Medical Examiner in To Be Completed by Fune	3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry Medical
re, Maryland 2121 s 1 and 2 should be filed within if Heelih and Mental Hygiene. Item 27 is marked other the Men other traumatic event. The Me		Claud.	First, Middle, Maiden Sumame)
ore, Mar ss 1 end 2 sh of Heelih and item 27 is m r other traum	Edd. Modica of Dioposition	Place of Disposition (Name of complete, comple	oute Number, City or Town, State, Zip Code) C. 29628 20c. Location - City or Town, State
altimore, permit. Peges 1 et Deperment of Hee Important: if item eny injury or othe once.	1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses	14. Spn. Ng Bypt. ST 1 8 6 22. Name and AGARDS OF FACILITY ROS 908 Kennedy ST	10 Anderson . S.C. INIU DC: 20011
760, te be executed Wedical Examiner Te burial-transit	23a. Part 1 Enter the dispesse, or complications that caused the dear shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consection of the consec	ith. Do not enter the mode of dying, such as cardiac or representations of the property of the control of the c	
P.O. Box 68 hat the death certifical of by the ettending phyledached for use as the Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ No 9 □ Unknown IF FEMALE: 23c. If yes, outcome of pregration 1 □ Live birth 2 □ Fellowship 1 □ Live birth 2 □ Fellowship 1 □ Unknown	al death 3 Ectopic pregnancy	23d. Date of delivery Month Day Year
ords, P. (quires that the signed by ould be detaced by Phy	Part II. Other significant conditions contributing to death but not re	sulting in the underlying cause given in Part I. OLONIC Adano carcinoma	23e. Did tobacco use contribute to the cause of death? 1 Per 2 No 3 Probably 4 Denknown
ral Records, n: The law requires the firete has been signed or page 2 should be completed by	Damon From Poptic Ulcar Discas 25. Was base referred to medical	26. Place of Death (24a. Was an autopsy performed performed death? 1 Yes 2 No
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physicien: The law requires that the death certifica within 24 hours effer death. To the Funeral Director: After this certificate has been signed by the ettending phy completely filled in by the funeral director, page 2 should be detached for use as the Medical Certification: To Be Completed by Physician/Medi	examiner? 1 Yes 2 No	DER/Outpatient 3 DOA Other: 4 Nursing Home 28b. Time of Injury M 28c. Injury at Work? M 1 Yes 2 No home, farm, street, factory, office 28	5 Residence 6 Other (Specify) d. Describe how injury occurred Location (Street and Number or Rural Route Number, City or Town, State)
Divisk To the Hospital or Attention within 24 hours effer death within 44 hours effer death completely filled in by the Medical Certifical	29a. Certifier 1 Certifying Physician: To the best of my kr	nowledge, death occurred at the time, date and place, an lation and/or investigation, in my opinion, death occurred	d due to the cause(s) and manner as stated.
To the within To the comple	29b. Signature and title of certifier	29c. License number 47867 om 23a) (Type, Print) LOIPH Pol. #ZIP, POCKI	29d. Date signed (Month, Day, Year) 7/30/10
CR 2 State	30. Name and address of person who completed cause of death (Ite ALY LUNISA 470 RANA 31. Date filled (Month, Day, Year) 32. Registrar's Sign	om 23a) (Type, Print) LO1/14 Pd #216, POCK (Action of the control of the contr	ille MD 20852.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 10 dward Month 08 Gradmal A. 0235 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Maryland Medical Ba HIMORE 7. Age (In vrs. last birthday) If Under 24 Hrs. If Under 1 Year Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1√2 M 2 □ F Months Days Min (Month, Day, Yea 05/28/39 **Director** 578-52-8426 Washington, D.C Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at Director 10d. Inside City Limits Maryland Frederick Frederick 1 🗆 Yes 🏻 No 10e. Street and Number items 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 8121 Broadview Drive 21701 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ō þ 1 Never Married 2 Married 1 Yes 22 If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 'natural", 1 ☐ Yes 2 ☐XNo Specify. White 3 Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) of Health and Mental Hygiene.
Item 27 is marked other than
other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Budget Analyst Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Edward Paul Lombard, Sr. Ruth Cleary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Department of Health ar Important: If item 27 is any injury or other trauonce. Mrs. Sandra Carlson Lombard. wife 8121 Broadview Drive, Frederick, MD 21701 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State Parklawn Mem. Park Aug. 9, 2010 Rockville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lie ²²Keeney and Fbasford PA Funeral Home M00255 106 East Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complice ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one Interval Betweer Immediate Cause (Final Onset and Death Subarrachnoid Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): weeks Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or s a consequence of) g physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE: nse s 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day been signed by the should be detached g 🗌 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy performed 2 1 No Yes 2 N Division of Vital 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Hospital 2 PNo Other: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Physicial 24 hours after death.

To the Funeral Director: After the completed filled in by the funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AU4176435P100554 MD08/04/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 777 S. Eden St. Apt. 631 Rutel Baltimore, MD

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

AUG 1 7 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 25682 State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day July 23, 2010 1640 hrs **lical Examiner** James Eldridge Lynch, Jr. 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Carroll Hampstead 4501 Foxtail Road If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number **Funeral** Count Maryland Min. Months Days Hours 04/29/1951 Director 219-56-7476 59 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits Oc. City, Town or Location 10a. State 10b. County 1 Yes 2 X No Carroll Hampstead Maryland filed within 72 hours after death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 4501 Foxtail Road 21074 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11. Marital Status 12. Was Decedent Ever in U.S White, etc. Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 X Married 1 X Yes specify: white If Yes, Give 1969-1973 1 Yes 2 X No specify: Divorced 3 Widowed Jre, MD 21215-0036
ss 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene.
If item 27 is marked other than "natural", ₽ 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Elementary/Secondary (0-12) law enforcement police officer 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Eldridge Lynch, Sr. Nancy Lee Wastler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Hampstead, Maryland 21074 Nancy L. Lynch - wife 4501 Foxtail Road 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) July 28, permit. Pages 1
Department of H
Important: If it 1 X Burial 2 Cremation 3 Removal from State Sparks, Maryland Bosley Cemetery 2010 Donation 5 Other Specify. 22. Name and Address of Facility Eline Funeral Home 21. Signature of Funeral Servi Jucensee Hampstead, Maryland21074 934 South Main Street M01072 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. Death /Medical a. Coronary Artery Thrombosis Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): b. Hypertensive Atherosclerotic Cardiovascular Disease Complicated by Hyperthermia Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit ian/Medical AMENDED #23a,ptII,perME,G906,8/27/2010,WS UNPENDED icate has been signed by the attending physician page 2 should be detached for use as the burial 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the Month Day Year 1 Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Yes 2 No 3 ✔ Probably 4 Unknown Chronic Obstructive Pulmonary Disease Completed Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? certificate has 2 No ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical e Hospital or Attending Physician: 24 hours after death, e Funeral Director: After this certif director, Be Other 4 examiner? Nursing Home 5 Residence 6 🗸 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗸 Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) FOUND: 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Subject exposed to high environmental FOUND: 1 Natural 1 Yes 2 ✓ No Division 5 Pending temperature the Jul 23, 2010 1630 hrs 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Single Family Home 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) 4501 Foxtail Road, Hampstead, MD Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the l within 2 To the 1 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi 29c. License number WJL July 24, 2010 BHIVA O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) DOME Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 Mary G. Ripple MD. 32 Registrar's Signature 31. Date filed (Month, Day, Year, State

DHMH 17 Rev 1/2001 OCMF 2006

Registrar

carrace JOK per ME

00

N

ORIGINAL

inda Lehner-C	Cose	State of Maryland / Department			nd Menta	al Hygien	e Reg.		10 25683
Physic Medical Exam		Decedent's Name (First, Middle,Last) Linda Cosey Lehner				Mont	of Death	av Yea	3. Time of Death 1737 hrs
		Aa. Facility Name (if not institution, give street and number) 808 Olive Branch Court	4	b. City, Town, Edgewood				4c. County of Harford	f Death
Funera Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth 220–54–1312 1_M 2\overline{X}F 53	hday) Yrs.	If Under 1 Ye	ear If Under ays Hours	N d inc	e of Birth(r /09/1		9. Birthplace (State or Foreign Maryland Country)
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hyggene. ant: If item 27 anaxked other than "natural", or items 23a or 28a-f show any or other transmatic event, the Medical Examiner must be notified at once.	ed by Funera		13. Was If Ye	10f. Zip Code 210 Decedent of Fis, specify Cubi	dispanic Originan, Mexican, Folio specify:	Puerto Rican, e	s or No-	White	American Indian, Black,
21215-0036 hould be filed within 72 h and Mental Hygiene is marked other than "n atte event, the Medical E	1 7	12 College (1-4 or 5+) Tollege (1-4 or 5+) College (1-4 or 5+)	•	eling T	ech	Name (First, M		Rehab	
MD 212' d 2 should be lth and Mental n 27 is marke sumatic event	To Be			Address (Stree	eet and Numbe		te Number		, State, Zip Code)
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Realth and Mental Hygiene. Important: If item 27 is marked other thinury or other traumatic event, the Med.		20a, Method of Disposition 1 Burial 2 Cremation 3 Removal from State cremator	f Dispositi ory or othe	ion (Name of c	emetery,	August 201	10. 20		City or Town, State
Balti permit. Departm Imports		21. Signatur Ineral Service Licensee 23a. Part Enter the cisease, or complications that caused the death. Do not	1 495	KITCH	ie hwv.		sever	ma rar	k Funeral Home k, MD 21146
he death certificate be executed by the attending physician and hed for use as the burial - transit		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): AMENDED 23a,27,28a			3907 9-	8-10 vi		23d. Date of d	Between Onset and Death
rds, P.O. Box 6876C requires that the death certificate been signed by the attending physically be detached for use as the brougld be detached for use as the brougld be	Physiciar	past 12 months? 1 Yes 2 No 9 V Unknown	Othe	I death 3 r (Specify)				Month	Day Year
law has 2 sl	Completed by I	Part II. Other significant conditions contributing to death but not resulting in	naule und			1 24a.	_	No 3 24b. We price dec	ute to the cause of death? Probably 4 ✓ Unknown ere autopsy findings available or to completion of cause of ath? Yes 2 No
of Vital Recing Physician: The After this certificate funeral director, page	: To Be	19 103 2 110	patient 3	3 DOA	e of Death (Ch Other ₄ N ury at Work?	ursing Home		dence 6	
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: Completely filled in by the fu	Certification	Accident 5 Pending Investigation 28e. Place of Injury - At home, farm 4 Homicide 6 Could not be determined (Specify) residence		iirs	Yes 2 X No	28f. Loca or To	tion (Street wn, State)	t and Number	pine and alcohor Rural Route Number, City
Divis To the Hospital or A within 24 hours after To the Funeral Dire	ledical (29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation on the control of the c	occurred estigation	d at the time, dans, in my opinion	ate and place,	and due to the	cause(s)	and manner as	s stated.
	ž	29b. Signature and title of certifier MU M M M M M M M M M M M M	7	29c. Licens O.C.				d. Date signed	(Month, Day, Year)
Ow		30. Namé an address of person who completed caus death (Item 23a) Russell Alexander MD. Assistant Medical Examiner		enn Street,	, Baltimore	, M D 21201			
St Regist	tate trar	31. Date filed (Month AUG 1 0 2010 32. Restar's Signature	pa	Ker	. = .				

OCME

		_ For	State of Ma		d / Depa	artment of H	lealth and M	-	_	0.5501		
		State Registrar	4\		Ce	rtificate of	Death	2. Date of Deat	leg. No. 2	3. Time of Death		
Physicia /Medic		Decedent's Name (First, Middle, L	Roland	Euge	ne McI	Intire		Month	Day Year 5, 2010			
Examine		4a. Facility Name (If not institution, g					r Location of Death		4c. County of Death			
<i></i>		12423 Walnut		a /In ima	la at hivth day		erstown If Under 24 Hrs.		Washington 9. Birthplace (State or Foreign			
Funeral Director		219-46-3063	Sex 7. Ag	65	last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day July 15	(, Year) C	Maryland		
and ow	ŀ	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	ocation				10d. Inside City Limits		
Maryl -f sho	to	Maryland Wash	ington			Hage	rstown			1 ☐ Yes 2 🕅 No		
h the	Director	10e. Street and Number				10f. Zip Code		1	10g. Citizen of What C	ountry?		
th wil		12423 Walnut Po	int West				21740		U.S.	4.		
r dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	10	s. 13. 6 4-	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi			
urs a	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2 □ If Yes, Give Year or Dates:	19		1 □Yes 2 □XNo	Specify:		Specify:	White		
"natural",	etec	15. Decedent's (Specify only highest of	Education grade completed)		(Give	edent's Usual Occup kind of work done	during most of work	ing	16b. Kind of Business	s/Industry		
within ene.	Completed	Elementary/Secondary (0-12)	College (1-4or s	5+)	IIIO.	DO NOT use retired Mainter	,		Truck	S		
filed Hygi other	Be Co	17. Father's Name (First, Middle, La.	st)		I			e (First, Middle, i	Maiden Surname)			
Alenta Alenta rked tic ev	10 B	John F. McInt.	ire, Sr.				Eve.	lyn G. Z	Zimmerman			
2 should be and Mental is marked c		19a. Informant's Name/Relationship			19b. Maili	ing Address (Street	and Number or Rui	ral Route Numbe	r, City or Town, State,	Zip Code)		
and and lealth m 27 her tr		Edith L. McIntire	e (Wife)							land 21740		
permit. Pages 1 and 2 should be filed within Department of Heath and Mental Hygina Important: If item 27 is marked other than any Injury or other traumatic event, Item once.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Special Contents)		Ce C		osition (Name of matory or other place NWM Memors Park	ial Aug	ust 9,	20c. Location - City o	own, State		
permit. Departr Importa any Inju	Ì	21. Signature of Funeral Service Lic	ensee Dwis	МО	1414 2	2. Name and Addre	ss of Facility Do	nald E.	Thompson I Maryland	Tuneral Home 21722		
		23a. Part 1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final	mplications that caused ly one cause on each li	d the death ne.	n. Do not en	ter the mode of dyin	ng, such as cardiac	or respiratory ari		Approximate Interval Between Onset and Death		
Physician /Medical Examiner		disease or condition resulting in death)	a. Amy on Due to (or as	a consequ	uence of):	ateral.	2 cleros	1.2		Byears		
xecuted and II-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	uence of):							
Sigi Be	= 1	that initiated events resulting in death) Last	c Due to (or as	a consequ	uence of):							
tificate g phy as the	ledic		u									
Physician: The law requires that the death certificate be extribing the securificate has been signed by the attending physician ral director, page 2 should be detached for use as the burial	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 🗌 Feta	I death 3	☐ Ectopic pregnanc ☐ Other <i>(specify)</i> _	ey		23d. Date of d Month	elivery Day Year		
ires that the de signed by the signed file of the si		Part II. Other significant conditions	contributing to death b	out not resu	ulting in the u	underlying cause giv	ren in Part I.	23e. Did to	bacco use contribute	to the cause of death?		
quires an sign uld be	ed by	chronic obsta	ictive pu	1 mo	nacy	diseas	2.	1 □ Y	es 2 ₩ 00 3□	Probably 4 Unknown		
The law requir	Completed							24a. Was a autopoperfor	sy prior to med? death?			
ician: T	BeC	25. Was case referred to medical					26. Place of Deat	1 □Yes th (Check only or		:S 2 140		
Physician: this certific al director,	일	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpati	ent 2	ER/Outpatie	ent 3 DOA Oth	ner: 4 🗆 Nursing H	ome 5 Resid	lence 6 □Other (Sp	pecify)		
ing After	tion:	27. Manner of Death 1	28a. Date of Inju (Month, Date)	ury ay, Year)	28b. Time o Injury	of 28c. Inju	ryat k? Yes 2 □No		ow injury occurred			
To the Hospital or Attendi within 24 hours after death. To the Euneral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not determine		iury - At ho	ome, farm, st	reet, factory, office		28f. Location (S City or Tow	Street and Number or i n, State)	Rural Route Number,		
n 24 hour n 24 hour ne Funera	Medical (Physician: To the best aminer: On the basis and manner st	of examina								
To the vithin com	Ź	29b. Signature and title of certifier Cyntha K	inther- 5	and	о мо	D4	745 j	2	August G	nth, Day, Year)		
5H 16+1		30. Name and address of person where the country of	no completed cause of	death (Iten	23a) (Type	Print) Wash	ington co	unty 7	47 North	and DITAZ		
Stat	e	31. Date filed (Month, Day, Year)	32. Registr	rar's Signa	ture		Tage	<u> </u>	1,			
Registra		31. Date filed (Month, Day, Year) AUG 0 6	2010 Done	ريها	A. A	and						

DHMH 17 Rev 1/2001

10-05676 Ma

arco: Melchor	State of Maryland / Department of Health and Mental Hygiene											
arco: Melchor	1- For State Contificate of Death										25585	
		Registrar 1. Decedent's Name (First, Middle,L	aet)		uncate or	Dealit		- 1	2. Date of De	Reg. No.		3. Time of Death
Physicia Jedical Examir	ши		relio	I	Melchor			_	Month July 29, 2	Day	Year	0902 hrs
		4a. Facility Name (if not institution, o	give street and number)		4	b. City, Town,	or Location	of Death			unty of Death	
*		11306 Woodland Drive				Brooklyn	Len	0.411	In D. 1. (D		imore Cou	
Funeral Director		,			ast birthday)		ays Hours	er 24Hrs. s Min.	⊣	./1943	Foreig	thplace (State or gn Juna/Lamala
Director		TIOTIC	XM 2 F	66	Yrs				10/12	./1943	0.0	unay.amaia
any	1	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Locati	on						10d. Inside City Limits
≜ .,		MD Balt	imore			F	Brookly	yn				1 Yes 2 X No
Aaryland 28a-f show 1 at once.	Director	10e. Street and Number				10f. Zip Code	•		T	10g. Citizen	of What Cou	ntry?
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	P	4116 Hague Ave.				2	21225 Guatamala					
h with	uneral	11. Marital Status	12. Was Decedent				ecedent of Hispanic Origin? (Specify Yes or No- specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bl White, etc.					
or ite	Fun	1 Never Married 2 XMarri	1 Yes 2	X No				_	atemala		cify: Whi	te
rs afte rral", miner	Š	3 Widowed 4 Divorce 15. Decedent's Education (Specify	ed if Yes, Give Year or Dates:	nleted)	16a. Deceden	Yes 2					of Business/	
2 hour	ted	Elementary/Secondary (0-12)	College (1-4 or			ost of working				Tob. Kind	01 2 40 11 10 00 1	in addity
336 thin 7, than than edical	ompleted	0		,	Far	mer				Ag	ricult	ure
21215-0036 Uld be filed within 7 Mental Hygiene. marked other than	S	17. Father's Name (First, Middle, La	st)				18.Mother's Name (First, Middle, Malden Surname)					
21; be fill ntal F rked	å	Pedro	Tobar	•			Fi	idel:	ina		Melch	or
2 21 hould hould Me is ma	P	19a. Informant's Name/Relationship	(Type, Print)		1/1	Address (St						e, Zip Code)
MD and 2 sho alth and 2 is raumati		Pedro A. Guerra 20a Method of Disposition	/ Son	206 1	4107 Place of Dispos	Hague	Ave. 7	#1F1	<u>Brook</u>		MD 2 Ition - City or	1225
nore, MD 21215-0036 ages I and 2 should be filed within 72 hours aften or of Health and Mental Hygiene. It: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner.		1 X Burial 2 Cremation	3 Removal from St	ate Com	crematory or oth	ner place)	1020	8/1	0/2010	Asun	cion M uatema	lita,
ti Pag tment rtant:		4 Donation 5 Other Spec	ify:									
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med	Į	21 Signature of Funeral Service Lice	M0153	9		ame and Addr app Fur						0910
Physician	-	23a. Part I. Enter the disease, or con	mplications that caused	the death.	Do not enter the	33 Gist ne mode of dyi	ng, such as c	ardiac or	respiratory ar	rest, shock,	or heart	Approximate Interval
Medical		failure. List only one cause on Immediate Cause (Final disease	each line. a Multiple Injuries									Between Onset and Death
Examiner		or condition resulting in death)	Due to (or as a conse	equence o	f):							
	اۃ ا	Sequentially list conditions, if any, leading to immediate	b	equence o	f)·							
		cause. Enter Underlying Cause	c.	7 daoi 100 o	.,,							
ed nsit	Examin	events resulting in death) Last	Due to (or as a conse	equence o	f):							
e executed cian and rial - transit		UNPENDED	d		_							
60, te be o	Physician/Medical	IF FEMALE:	23c. If yes, outcor	ne of preg	nancv					23d. Da	ate of deliver	<u> </u>
587 srtifica fing pl	an/	23b. Was decedent pregnant in the past 12 months?	1 Live birth		2 Fet	al death	3 Ectopio	c pregnai	ncy	Mor		Day Year
Box 68760, e death certificate be the attending physic et for use as the bur	Sici	1 Yes 2 No 9 Unkno	4 Pregnant at wn 9 Unknown	time of de	eath 5 Oth	ner (Specify)				4		
the de	P	Part II. Other significant condition		n but not re	esulting in the u	nderlying caus	e given in Pa	art I.	23e. Did	obacco use	contribute to	the cause of death?
ires that the signed by t	d by								1 Ye	s 2 🗸 No	3 Prot	oably 4 Unknown
ords, w requir	ompleted								24a. Was			topsy findings available
CO le law te has ge 2 sl	dm								auto perfo 1 ✓ Yes	ormed?	death?	
Vital Recysician: The his certificate director, page	O	25. Was case referred to medical	 			26.Pla	ace of Death	(Check o		2 100	1 🛕 1.0	2 110
Vita hysicia this ce	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatie	ent 2	ER/Outpatient	3 DOA	Other ₄	Nursing	Home 5	Residence	6 🗸 Other	r: Scene
ing Ph After t	li.	27. Manner of Death	28a. Date of Inju (Month, Day Y Jul 29, 2010	iry ear)	28b, Time of Ir		njury at Work	. !!	28d. Describe Subject str			
ttendi death.	atio	1 Natural 5 Pending 2 ✓ Accident Investig	ation		0849 hrs	_	Yes 2	No No		_		
Division of Vital Records, tal or Attending Physician: The law requirers after death. The The tall the tall the certificate has been sited in by the funeral director, page 2 should be the tall or the funeral director.	Certification:	3 Suicide 6 Could n	ot be		ome, farm, stree	et, factory, offic	e building, et	- 1	or Town,	State)		Produkte Number, City
ospita hours nneral y fille	1	4 Homicide	(Opcony) Va									Brooklyn, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Medical	(Check only	ician: To the best of mer: On the basis of exa									
To To con	Mec	29b. Signature and title of certifier	and manner stated.	-		29c. Lice	ense number			29d. Date	signed (Mo.	nth, Day, Year)
4		Add An	1/1/1			0.0	C.M.E.			July 30	, 2010	
,	ŀ	30. Name and address of person wh	no completed cause of c	eath (Item	23a)					1		
			Assistant Medical			enn Street	Baltimore	e, MD	21201			
Sta Regist	ate	31. Date filed (Month, Day, Year)	32. Registra	/50	park .	1						
Regist	цец	MUG VU ZU	A AMARIAN	10	C/							

DHMH 17 Rev 1/2001 OCME 2006

OCME

			For State Registrar	State of Ma			tment of H <i>ficate of L</i>			gieng 0 1 0	25686
ı	Physicia		Decedent's Name (First, Middle, Las Anna Mae MCDONALI						2. Date of De Month	Day Year	3. Time of Death 8:45 p M
N. T.	/Medic Examin		4a. Facility Name (If not institution, give			4	b. City, Town, or	Location of Death	July	29 2010 4c. County of Dea	
۸,	Funeral		Julia Manor Nursi 5. Social Security Number 6. Security Number	7. Age	(In yrs. last birtl		Hager If Under 1 Year Wonths Days	stown If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	Washin (h, Year) 9. Bi (13 1923 Per	rthplace (State or Foreign ountry)
	Director		172-24-9076 Usual Residence of Decedent		<u> </u>				Whill	13 1923 Fel	msyrvania
	ryland		10a. State 10b. County		10c. City, Town	or Loca	tion				10d. Inside City Limits
	8a-f	Directo	Maryland Washing	gton	H	ageı	cstown				1 ☐ Yes 2 No
	a or 2		10e. Street and Number				10f. Zip Code			10g. Citizen of Whal C	ountry?
	ne 23	erai	11521 Greenberry 11. Marital Status	Road 12. Was Decedent E	ver in U.S.	13 Wa	2174		ecify Yes or No	USA - 14. Race - Am	erican Indian.
396	be filed within 72 hours after death with the Maryland itel Hygiene. In the "matural", or items 23a or 28a-f show ovent, the Medical Examiner must be notified at event,	by Funerai	1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:			es, specify Cuba ∃Yes 2[X]No	spanic Origin? (Sp n, Mexican, Puerto Specify:	Rican, etc.)	Black, Wh	
Š	2 hou	ted	15. Decedent's Ed		16a.	Deceder	nt's Usual Occupa	ation	ina	16b. Kind of Business	
Maryland 21215-0036	within 7 jiene.	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5-	+)		on work done of NOT use retired, emaker	luring most of work)	ing	Her own	home
פ	should be filed ad Mentel Hygin marked other imatic event, I	BeC	17. Father's Name (First, Middle, Last)		,		martor	18. Mother's Nam	e (First, Middle,	Maiden Surname)	Trouic
<u>a</u>	should be and Mentel s marked o umatic eve	To	Isaac Waldo Duleb	ohn				Carrie	Naomi F	lege	
Jar	2 e e	Ì	19a. Informant's Name/Relationship (7		1					er, City or Town, State,	
	1 and 2 Health Iem 27 other tra	,	James E. McDonald 20a. Method of Disposition	- Husband	20b. Place of	Disposit	ion (Nama of		Hagers Date	20c. Location - City o	21740 r Town, State
nor	Pages 1 ar		1X Burial 2 ☐ Cremation 3 ☐		cemetery	, crema	tory or other place	e)			
altimore,	permit. Pages Depertment of Important: If it any injury or o	Ī	4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen		ML. Ia	_	Luth. Cen		ASSESSMENT OF THE PARTY OF THE	Funeral Ho	ng, Maryland
m	Den imp		Molet & Van	l:		415	E. Wils			stown, Mary	
	Dhusisian		23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final	olications that caused one cause on each lin	the death. Do n	ot enter	the mode of dying	g, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
)	Physician /Medical		disease or condition resulting in death)	Due to (or as a	Consequence of	of);					57
	Examiner		Sequentially list conditions	Cereb	x016500	lax	Acc	ident	_		34
	pa sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence o	if):	• / /	11.	1	Disense	2
	xecute and	хаш	that initiated events resulting in death) Last	c. Hanero (or as	consequence of	h):	Card	Vowa Sca	Var	VISENSE	38×
68760,	ificate be executed g physicien and as the burial-transit	edical E		4							/
_	fificat ng phy as th	Medi	15.55.11.5	-							
Вох	at the death certifi by the ettending I stached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome of 1 Live birth 4 Pregnant at	2 Fetal death		ctopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year
0.	at the by the	hys	9 Unknown	9□ Unknown							
	w requires that been signed I should be det	þ	Part II. Other significant conditions of	ontributing to death bu	t not resulting in	the und	erlying cause give	en in Part I.		obacco use contribute Yes 2□No 3□F	to the cause of death? Probably 4 Munknown
Division of Vital Records,	2 8 8	Completed							24a. Was auto perfo	an 24b. Were a prior to death?	
ā		BeC	25. Was case referred to medical examiner?					26. Place of Deat			
<u>></u>	Physic this car	٩	1 ☐ Yes 2 No	Hospital: 1 Inpatier			3□ DOA Othe	4 Parvursing Inc		dence 6 ☐Other (Sp	ecify)
n C	After After funer	ion	27. Manner of Death 1	28a. Date of Injur (Month, Day		ime of ijury	28c. Injury Work	yat ⟨? Yes 2 □ No	28d. Describe	how injury occurred	
<u>isi</u>	i or Attencatter death Director:	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Inju	ry - At home, far	m, stree		165 2 1140	28f. Location (Street and Number or I	Rural Route Number,
á	s after s after al Dire ed in by	Certification:	4 Homicide determined	building, etc	. (Specify)				City or To	wn, State)	
	To the Hospital or within 24 hours after To the Funeral Director completely filled in	Medical (29a. Certifier (Check only one) Continue (Check only one)	ysician: To the best on hiner: On the basis of and manner sta	examination and	, death o	occurred at the tim stigation, in my op	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) and manner a date and place, and du	as stated. ue to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		•		29c. License			29d. Date signed (Mor	
			00	25			DS	2323		07-3	2010
31	4-1		30. Name and address of person who								
ا <i>ا</i>		t a	Khalid Waseem 31. Date filed (Month, Day, Year)	1126 Opa:	L Court,	Hag	gerstown	, Maryla	nd 21742	2	
15	Sta Registr	_	AUG 932	010	1	h	entel				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2:00 A M 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore University of Maryland Medical Center If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 **№** м 2 🗆 ғ Days Hours Min. Aug 3 154-32-5411 New Jersev **Director** 69 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he maritimal at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 🗌 Yes 2 🛣 No Maryland Kensington Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20895 11410 Cam Court United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Institute of Law & Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Attorney Justice Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Bernard Miller Selma Kramer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa E. Miller/wife Maryland 20895 11410 Cam Court Kensington, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 8/3/2010 Woodbine, Maryland 21. Sign e of Funeral Service Licer Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 M00957 23a. Part There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ Ischenuc Cardia disease or condition resulting in death) years Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed? Yes 2 No this certificate 1 ☐ Yes 2 ☐ No To the Funeral Director: After this certific completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🗹 No Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d, Date signed (Month, Day, Year) 992020457 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, Maryland State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State of Maryland / Department of Health a Certificate of Death	and Me		eg. No. 2010	0 25688
	Physici	an	1. Decedent's Name (First, Middle, Last)		Date of Death Month	Day Yea	
	/Medic		Jeanne L. Maurer 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location o		July	30, 2010	
	Examin	ier	Kline House Mt. Airy	or Death			lerick
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2		Date of Birth	9.	Birthplace (State or Foreign
	Director		577–36–6149 1□ M 2 ☐ F 80 Yrs. Months Days Hours	Min. O	(Month, Day,		Massachusetts
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Aaryle f sho	ŏ					1 ☐ Yes 21 No
	the N	Director	Maryland Frederick Mt. Airy 10e. Street and Number 10f. Zip Code		10	0g. Citizen of What	Country?
	h with	al D	1101 Oak View Drive 21771			Unite	ed States
	deat ems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Orlo	igin? (Specif	y Yes or No-	14. Race - A	American Indian,
2-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinating be rediffied at once.	þ	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates;		an, etc.)	Specify: W	/hite, etc. /hite
<u>ر</u>	72 ho "natur	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most	t of working		16b. Kind of Busine	ss/Industry
N	within ene. than	mg	Elementary/Secondary (0-12) College (1-4or 5+)			** 7	
D	filed Hygie		2 Nursing Assistan 17. Father's Name (First, Middle, Last) 18. Mother		First, Middle, N	Heal Maiden Surname)	thcare
and	ld be lental ked c ic eve	To Be		eggy?	,	,	(unk)
ary	shou and N s mar umat	-	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number		Route Number,	City or Town, Stat	· ,
, Ma	and 2 salth a n 27 is		John F. Maurer/husband 1101 Oak View Drive	e Mt.	Airv.	Maryland	L 21771
ore,	of He		20a. Method of Disposition 1 □ Burial 2 ▼ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date		20c. Location - City	
OE II	Pages 'ment of lant: If ite		4 Denation 5 Other (Specify) Final Journey Crematory				Maryland
0	permit Depar Impor any in once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Going Home Crem Beverly L. Heck	nation crotte	Service.	ce P.O. B	ox 784
			23a. Part \ Finter the disease, or complications that caused the death. Do not enter the mode of dying, such as shoot, or heart failure. List only one cause on each line.	cardiac or re	espiratory arre	est,	Approximate Interval Between
1	Physician		immediate Cause (Final disease or condition				Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):				100.
	LAdiiiilei	<u>-</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
	uted f rnsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.				
ב ב	e exec an an	Еха	resulting in death) Last Due to (or as a consequence of):				
0/00,	eath certificate be executed attending physician and for use as the burial-transit	edical	d				
00	ertifica ing ph e as th		IF FEMALE:				
Š	ath cattend	sician/N	23b. Was decedent pregnant in the past 12 months?			23d. Date of Month	delivery Day Year
5	uires that the de signed by the d be detached t	ysic	1 ☐ Yes 2 DNo 4 ☐ Pregnant at time of death 5 ☐ Other (specify)				
ŗ	that the	y Phys	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tob	acco use contribute	e to the cause of death?
200	quires an sign	ed by			1	s 2 370 No 3 □] Probably 4 ☐ Unknown
ט כ	aw requii is been s 2 should	olete		1	24a. Was ar		e autopsy findings available
č	hysician: The law his certificate has build director, page 2 sl	Completed			autopsy perform 1 □ Yes 2	y prior ned2 death	to completion of cause of h? Yes 2 🗆 No
ומ	ctor, I	Be	examiner/	of Death (C	Check only one		2 2 110
5	Physic this c al dire	일	1 ☐ Yes 2/1 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nur	rsing Home	5 ☐ Reside	nce 6 Dother (S	Specify) HOSDICE
5	nding Phy ath. r: After thi e funeral c	ation:	27. Manner of leath 1 Natural 5 Pending (Month, Day, Year) 2 Accident investigation 28a. Date of Injury 28b. Time of Injury Work? 1 Accident investigation 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 N		I. Describe ho	w injurý occurred	,
2	or Atte after deg Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f.	Location (Str City or Town	reet and Number or , State)	r Rural Route Number,
	To the Hospital or Attending Physician: The law requires that the death cen within 24 hours after death. Within 124 hours after death. To the Luneral Director. After this certificate has been signed by the attendit completely filled in by the funeral director, page 2 should be detached for use		29a. Certifier Check only Ch	nd place, and ath occurred	d due to the ca at the time, da	ause(s) and manne ate and place, and	er as stated. due to the cause(s)
	Го the within 2 Го the somple:	Medical	one) and manner stated. 29b. Signature and title of certifier 29c. License number			9d. Date, signed (Mo	
	⊢s⊨ŏ		DERIC TOUR MAN DERIC	711		7/20	2010
,	, ,		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)) 4		11 301	2010
	10		Fre Bushmo SIL Tros Ave Frederick	mo	2170	2	
	Star Registra		31. Date filed (MANIGOVO 33) 2010 34. Registrar's Signature				

DHMH 17 Rev 1/2001

			For State Registrar	State of	Maryland		artment of F	lealth and N Death	/lental Hy	giene Reg. No.	25689
	Physicia		1. Decedent's Name (First, Middle, Barbara	_{Last)} Ann Mille	r				2. Date of De Month AUGUS	ath Day Year	3. Time of Death
	Medio Examir		4a. Facility Name (if not institution, g	rive street and numb	er)			Location of Death	Nogus	4c. County of De	
Ī	Funeral Director				Age (In yrs. las		If Under 1 Year Months Days		8. Date of Bir (Month, Da	th 9. E	sirthplace (State or Foreign country) rtn Carolina
•	land show dat	tor	Usual Residence of Decedent 10a. State 10b. County	•	10c. City,	Town or Loc			-	, 1500 1110	10d. Inside City Limits
	th with the Maryland ms 23a or 28a-f show must be notified at	Funeral Director	Maryland Ce	cil		· ·	Port De		Т	10g. Citizen of What (1 🗆 Yes 2 🎾 No
	eath with ems 23a r must b	unera	116 Waibel Road	12. Was Deced	ent Ever in U.S.	13, V	Vas Decedent of Hi	21904	cifv Yes or No-		S.A.
980	72 hours after death with the Maryland n"natural", or items 23a or 28a-f sho dedical Examiner must be notified at	by	1 🏻 Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Force d 1 Yes 2 If Yes, Give Year or Date	2 💢 No		Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto Specify:	Rican, etc.)	Black, Wh	
\mathcal{MM}	permit. Page 1 and 2 should be filed within 72 hours after death v Departit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once.	Completed	15. Decedent' (Specify only highest Elementary/Seconday (0-12)	grade completed) College (1-4	or 5+)	(Give k	NOT use retired)	uring most of worki	ing	16b. Kind of Busines Magraw-Woo	
nd 94	filed with tal Hygien of other t event, the	Be	17. Father's Name (First, Middle, Las	-		-	Paraleg	18. Mother's Name			Maryland
	hould be and Meni s marke	10	Ado I phus 19a. Informant's Name/Relationship	B. Mille	er	19b. Mailin	g Address (Street a		aura E.		Zip Code)
3	and 2 sl Health a tem 27 is		Joseph S. Mille	er	20b Pla		Timberla		Strasbu	r, City or Town, State, 2 urg, Virgin 20c. Location - City of	
7~7	Page 1 tment of tant: If i jury or o		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	ecify)	tate cer	metery, crem	Cemeter	e) !	5/10	·	it, Maryland
	permii Depar Impor any in	, y	21. Signature of Funeral Service Lic	ense	Mon. S	ر ²² ا	Name and Addres Pat Perr	terson & yville, M	Son Fur laryland	neral Home 1 21903-07	P.A.
01/1/	Physician	2 10	23a. Part 1. Enter the disease, or co shock, or heart failure. List onl Immediate Cause (Final disease or condition	omplications that can y one cause ach	used the death.	Do not enter	r the mode of dying	, such as cardiac o	r respiratory an	rest,	Approximate Interval Between Onset and Death
80	Medical Examiner		resulting in death)	a. Du jo (or	as a conseque	nce of):	astas	1			
\$030 1	rted of	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	b. Deerg (or	as a conseque	rice of):					
701	death certificate be executed death certificate be executed the attending physician and ed for use as the burial-transit	dical Ex	that initiated events resulting in death) Last	Due to (or	as a conseque	nce of):					
22 S	eath certificate attending phy for use as the	/Med	IF FEMALE:	23c. If yes, outco	me of pregnanc						
r Dara	t the death or by the atten tached for us	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 🔲 Live Bir	rth 2 🗀 Fetal on the at time of dea	death 3 🗌	Ectopic pregnancy Other (specify)	<u>'</u>		23d. Date of d Month	elivery Day Year
\$ 2	thai ned e de		Part II. Other significant conditions	contributing to dea	th but not result	ting in the ur	nderlying cause give	en in Part I.	23e. Did to	obacco use contribute t	o the cause of death?
Heri	The law requires cate has been signage 2 should b	Completed by							24a. Was a autop	sv /1 prior to	utopsy findings available completion of cause of
Mital R	ysician: The is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:	/	-		ce of Death (Check			es 2 No
7	ding Physi h. After this c	ite: To	1 ☐ Yes 2 ☐ No 27. ann of Death 1 Natural 5 ☐ Pending	1 In 28a. Date of	patient 2 EF injury 28 Day, Year)	R/Outpatient 8b. Time of injury	3 DOA Other	4 Nursing Horat		ence 6 Other (Spe	cify)
5090 Division	To the Hospital or Attending Physician: The law requires within 24 hours after death. To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be	Certificate:	2 Accident Investigat 3 Suicide 6 Could no 4 Homicide determine	ion t be 28e. Place of				res 2 □ No	28f. Location (S City or Tow	treet and Number or Ro n. State)	ural Route Number,
m_{∞}	ospital of hours a uneral D	Medical C	29a. Certifier 1 Certifying Pl	nysician: To the bes	t of my knowled	lge, death o	ocured at the time,	date and place, and	due to the car	ise(s) and manner as s	tated.
38	To the H within 24 To the F complete		only one 3 Certifying N 29b. Signature and title of certifier	ree Pranticher T	the sest of my li	nd/or investig	29c. License	time, data and place	i, and due to the	nd place, and due to the course used in the course of the	s stated,
5			20 Name and oddress of	o completed	MD	20) (5	206	66 [8/10	
	8		30. Name and address of person wh	7.669 K	Povolu	tion	ST H	oure d	e Gra	ce MP	21078
	Stat Registra	_	AUG 0 4 2010	Benus 32. Regi	istrar's Signatur	are					

State of Maryland / Department of Health and Mental Hygiene 25690 for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 30, Day 2010 12:45 PM Darlene Faye Muse Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 3602 Branhum Road Edgewater Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🛛 F Months Hours Maryland 63 (Month, Day, Year) 10/30/1946 213-46-3729 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Maryland Anne Arundel Edgewater 1 ☐ Yes 2 🔀 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 3602 Branhum Road United States 21037 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. ò ò 1 Never Married 2 X Married 1 Yes 2 If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural", Completed 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Mericall once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Realtor Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Gilbert Bauerlien Ella Mae Esworthy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kerry Muse / Husband 3602 Branhum Road, Edgewater, MD 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State Kalas Crematory 08/05/2010 Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signati icensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Physician: The law requires that the death certificate be executed ending physician and use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) Day Year detached 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tes this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 ☐ Yes 2 ☐ No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 No Other: Certificate: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
28d. Describe how injury occurred 1 Inpatient 2 Inpatient 3 Inpotent 2 Inpatient 3 Inpotent 2 Inpatient 3 Inpotential DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No e Hospital or Attending Pl 124 hours after death. e Funeral Director: After th 1 Natural 5 Pending Accident after death

Director: A
d in by the f Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Cod Date second (Month, Day) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Signature a 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stuart E. Selonick, M.D. 900 Bestgate Road, Annapolis, MD 21401 egistrar's Signatu AUG 0 2 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 25691 StateRegistrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 2010 James Harvey Meadows Jr. 11:25 pm Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 538A Stevens Rd. Rising Sun Ceci1 If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) PA 8. Date of Birth **Funeral** Aug • 27 1 🕅 M 2 🗆 F Months Days Hours Min. 63 Yrs Director 217-48-4488 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 ¥ Yes 2 □ No MD Ceci1 Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 538A Stevens Rd. 21911 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ☐ Yes 2 🛛 No þ 1 X Never Married 2 Married 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Specify: White Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Farmer Agriculture Be 17. Father's Name (First, Middle, Last) Maryland 18. Mother's Name (First, Middle, Maiden Surname) မ James Harvey Meadows Sr. Helen Riale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Johanna Holton/ Niece 544 Stevens Rd. Rising Sun, MD 21911 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 8/5/2010 1 XBurial 2 Cremation 3 Removal from State Colora, MD West Nottingham Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses Name and Address of Facility T. Foard Funeral Home 11 S. Queen St. Rising Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one gauge on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transli that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year 9 Unknown 9 Unknown this certificate has been signed by ral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 XNo Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 A Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Yes 2 No Director: A Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C Medical 29a. Certifier Surtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. title of certifier Sign 29c. License number 29d. Date signed (Month, Day, Year) address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

		•	1 - State Of IVIS	aryland / Depa Cer	artment of F tificate of L			eg. No.	25692
ı	Physicia		1. Decedent's Name (First, Middle, Last) Theodore Winton Merr	ill			2. Date of Death July 30		3. Time of Death 6:37 a M
	Medic Examin		4a. Facility Name (if not institution, give street and number) 4644 Little Mill Road		4b. City, Town, or Stockt	Location of Death		4c. County of Dea	ith
	Funeral		5. Social Security Number 6. Sex 7. Age	e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	9. Bi	rthplace (State or Foreign
	Director		Usual Residence of Decedent	78 Yrs.			10/21/1	931 7	Ohio
	faryland Ba-f sho tified at	ector	10a. State 10b. County Maryland Worcester	10c. City, Town or Loc Stockto					10d. Inside City Limits 1 ☐ Yes 2 🔀 No
	s 23a or 28 s with the N	teral Dir	10e. Street and Number 4644 Little Mill Road		10f. Zip Code 21864	1	1	0g. Citizen of What C	ountry?
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent E Armed Forces? 1 Mess 2 I If Yes, Give Year or Dates.	No	Was Decedent of Hi f Yes, specify Cuba ☐ Yes 2 🔻 No	ispanic Origin? (Spe n, Mexican, Puerto l Specify:	cify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify: W	
21215-0036	within 72 hor giene. er than "nat the Medica		15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5	(Give k	lent's Usual Occupa kind of work done d O NOT use retired) ineer	ation luring most of workii	ng	16b. Kind of Business	
Maryland	id be filed v Mental Hyg arked othe atic event,	To Be	17. Father's Name (First, Middle, Last) Robert Merrill			18. Mother's Name Dora wi		aiden Surname)	
, Mar	ind 2 shou lealth and im 27 is m		19a. Informant's Name/Relationship (Type, Print) Sandra Merrill/spouse	4644	4 Little		Stockto	City or Town, State, Z.	64
Baltimore,	t. Page 1 a tment of h tant: If ite ijury or otl		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispos cemetery, crem Salisbury	natory`or other plac	e) :		Salisbury	
Bal	permit Depar Impor any in once.		21. Signature of Fundal Service Licensee	22	Holloway 107 Vine	Funeral F St., Pocc	Home Protomoke Cit	fessional ty, MD 218	Association 51
	nysician/ Medical			CANCER	er the mode of dying	g, such as cardiac o	r respiratory arres	it,	Approximate Interval Between Onset and Death
	Examiner	L	Sequentially list conditions	a consequence of):					
	rted d ansit	amine	if any leading to in a solution of said cause. Enter Underlying Cause (Disease or iiniury	i consequence of:				31	
0	cate be executed physician and s the burial-transit	ledical Examiner	that initiated events resulting in death) Last C. Due to (or as a	consequence of):					
	irtificate ling phy e as the		IF FEMALE: 23c. If yes, outcome of						
Вох	he death certifi y the attending iched for use a	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	2 🗆 Fetal death 3 🗌	Ectopic pregnance Other (specify)	у		23d. Date of de Month	blivery Day Year
ds, P.O.	Physician: The law requires that the death certific this certificate has been signed by the attending praid director, page 2 should be detached for use as		Part II. Other significant conditions contributing to death bu	nt not resulting in the ur	nderlying cause give	en in Part I.		acco use contribute to	o the cause of death? Probably 4 🗆 Unknown
Division of Vital Records,	The law ate has page 2	Completed by					24a. Was an autopsy perform	prior to death?	topsy findings available completion of cause of
Vital	ysician: The is certificate director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatie	ent 2 ER/Outpatient	Othe	er:		nce 6 🗆 Other (Spec	rifu)
on of	ending Physiath. Tatter this The funeral di	Certificate:	27. Marrier of Death 1 Natural 5 Pending 2 Accident Investigation	y 28b. Time of	28c. Injury work	at 2	8d. Describe how		
Divisi	al or Atten	Certif	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injurbuilding, etc.	ry - At home, farm, stre (Specify)	et, factory, office	2	28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
	to the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	29a. Certifier (Check only one) 1	amination and/or investi	igation, in my opinioi	n, death occurred at	the time, date and	place, and due to the	cause(s) and manner stated.
	To the I within 2 To the I complet		29b. Signature and title of certifier M	()	29c. License	number 4127	29	d. Date signed (Mont	h, Day, Year)
ZĬN	10+1		30. Name and address of person who completed cause of de	eath (Item 23a) (Type, Pr	rint) Scullshi	ury ms	2180	24	
	Stat Registra		31. Date filed (Month, Day, Year) AUG 0 3 2010 32. Refistrar	r's Signature	arke	J			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** CARLEAN M. MC CLELLAN 26, 2010 /Medical JULY 4:15 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HEARTLAND HEALTH CARE CENTER HYATTSVILLE PRINCE GEORGE"S 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** 1 □ M 2 □ MF Director 579-38-1807 84 2/22/1926 Luvern, Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show "natural", or items 23a or 28a-f shor idical Examiner must be notified at 1 XYes 2 No Directo Maryland Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6500 Riggs Road 20783 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black 3 → Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 s 1 and 2 should be filed w f Health and Mental Hygier ftem 27 is marked other th Domestic Worker Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Nathan Moore Ella Mae King 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr Gregory Moore / Son 609 Severn Drive Virginia Beach, Virginia 23455 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/30/2010 Laurel, Maryland Maryland National 21. Signature of Funeral Service License 22. Name and Address of Facility Pope Funeral Homes, P.A. 0101085 5538 Marlboro Pike Forestville, Maryland 20747 23a. Party Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): xaminer andiovaseula Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Cardiniaseular Discuso. burial-tran and Box 68760. nding physician pe tunsion Physician/Medical the as IF FEMALE: asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery atter 3 ☐ Ectopic pregnancy in the past 12 months? for 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 ☐ Unknown been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 3 post combinascular 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hiknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No cate has autopsy perform certificate ridom ce 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Yes 2000 ို After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: ospital or Attending I hours after death. 5 Pending investigation vithin 24 hours after vec.....

To the Funeral Director: After a commendate of the funeral birector. 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) reperson who completed cause of death (Item 23a) (Type, Print)
(Night 4701 Randolph Rd#216. ROCKVILK, MID 20852 31. Date filed (Month, Day, Year) AUG 0 2 2010 .32. Registrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 7^{Day} **Physician** WAYNE ELLIS MOXLEY AUG 8:05 20°1°0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WASHINGTON HOMEWOOD - HILLTOP ASSISTED LIVING WILLIAMSPORT If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Country 1 X M 2 □ F 90 8/30/1919 520-03-3395 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show other traumatic event, the "Molical Examinar is ust be retified at WASHINGTON WILLIAMSPORT Director 1 ☐ Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 16505 VIRGINIA AV 21795 USA items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 X No Specify: þ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) s 1 and 2 should be filed within of Health and Mental Hygiene. Item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) WESTERN ELECTRIC TROUBLESHOOTER 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) JAMES MOXLEY HAZEL "UNKNOWN" 2 Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print)
JOY JUANITA MOXLEY (WIFE) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 16505 VIRGINIA AVE. HILLTOP B112, WILLIAMSPORT, MD 21795 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition AUGUST 9 Department of I Important: If ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State SMITHSBURG CREMATORY 2010 SMITHSBURG, MD 4 ☐ Donation 5 ☐ Other (Specify) permit. 21. Signature of Funeral Service Licenses 7010 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician DEATH FEWMIN ACUTE CAZDIAC resulting in death) /Medical Due to (or as a consequence of): Examiner MYPERLIPIDEMI Sequentially list conditions, if any because. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of The law requires that the death certificate be executed ending physician and use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown as been signed 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ MTPERTLASION Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has b rector, page 2 st 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed' 1 ☐Yes 2 ☐No 1 ☐ Yes 2 ☐ No or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 POther (Specify) AJS (5759 1 ☐ Yes 2 ☑ No Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 4 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital 1 Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

alt mo

OM AFFLD FURLAV

32. Registrar's Signature A. fall

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8210

340

MILLIT

18019

HAGERSTOWN

AUGUST

MO 21748

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

þ

Completed

Be ပ MD

"natural", or Items 23a or 28a-f shovedical Examiner must be notified at

filed within 72 hours after death with Hygiene.

permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical

Baltimore, Maryland 21215-0036

burial-tran nding physician use as the buria use as signed by t peen s certificate has e Hospital or Attending Physician; 24 hours after death. Funeral Director: After this certifica

filled in by

within 24

Medical

P.O. Box 68760

Division or Vital Records,

Examiner Physician/Medical þ Completed funeral director, Be 2 Certification:

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

4 ☐ Homicide

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury

5 ☐ Pending investigation 1 Tyes 2 □ No 6 ☐ Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0066116

Haperstown,

28f. Location (Street and Number or Rural Route Number, City or Town, State)

MD, 21740.

29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr

31. Date filed (Month, Day, Year) State Registrar



DHMH 17 Rev 1/2001

05772			or Print in Bl						gible.	05000
mmy Shives		চারা 1- For State	e of Maryland		tificate d		iu ivierita		2010	25696
Physicia		Registrar 1. Decedent's Name (First, Middle,I	ast) Tammy Sh					2. Date of Dea		3. Time of Death
edical Exami			Tammy El	izabc	th My			Month August 1,		1050 hrs
		4a. Facility Name (if not institution, 208 North Cannon Aver				4b. City, Town, o		Death	4c. County of Dea Washington	th
Funeral				e (In yrs. la	ast birthday)	If Under 1 Ye		4Hrs. 8. Date of Bi	rth(MM/DD/YYYY) 9. B	
Director		242 24 2226		27	, Y	Months Da	ays Hours	Min. August	: 19,1982 Fore	ign ountry) <i>Maryland</i>
		Usual Residence of Decedent								10d. Inside City Limits
ow any		10a. State 10b. County		10c. City,	Town or Loca		nat our			1 V Yes 2 No
ryland a-f sh		Maryland Wash 10e, Street and Number	ington	l,		10f. Zip Code	rstown		10g. Citizen of What Co	untry?
ith the Maryland 23a or 28a-f show any notified at once.	Directo	208 North Can	non Ave.			2	1740		U.S.A.	
with t ms 23a be not	eral	11. Marital Status	12. Was Decedent					? (Specify Yes or No uerto Rican, etc.)	o- 14. Race - Ame White, etc.	erican Indian, Black,
r death	Funeral	1 Never Married 2 Marr	1 Yes 2	X No	"			uerto rricari, etc.)		White
rs afte ural",	ē	3 Widowed 4 X Divor	or Dates:	npleted)	16a. Decede	Yes 2 X N		d of work done	Specify:	
72 hou n "nat al Ex	Completed	Elementary/Secondary (0-12)	College (1-4 or		during	most of working li		e retired)	G 1.	7.7
one re than Medic	du	10				Supervi			Goodwi	<i>L. L.</i>
filed v Hygi of other		17. Father's Name (First, Middle, L Samuel E. M	•					Name (First, Middle, Stacey L.		
212 uld be Menta marke	To Be	19a. Informant's Name/Relationship	and the state of t		19b. Maili	ng Address (Str			mber, City or Town, Sta	te, Zip Code)
MD 12 sho th and 27 is umati	7	Stacey L. Knox	(Mother)						ryland 217	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Higgiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 Cremation	3 Removal from St	ate	crematory or			Date August 4,	20c. Location - City	or Town, State rg, Maryland
Page ment or tant:		4 Donation 5 Other Spe	cify:	Smi	100	rg Crema		2010		
Ball permit Depart Impor		21. Signature of Funeral Service Li	censee	MO 1	414	Name and Address			avis Funer hsburg. Ma	al Home ryland 21783
Physician		23a. Part I. Enter the disease, or confailure. List only one cause of		the death.						Approximate Interval Between Onset and
/Medical	8	Immediate Cause (Final disease	a. Undeter	mined	Asph	yxia				Death
7		or condition resulting in death)	Due to (or as a cons	equence of	f):					
	Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a cons	equence o	f):					
J	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	equence o	f):	-	-			
executed an and al - transit	cal Ex		d	о - т	27	704 500	MF GU	84 2/27/1	4 TRC	
D, be exe sician a		X UNPENDED	-77,23a	2 / 2 و ا	28a-i,	per ME	g910 12	2/20/10 T		_
876 tificate ng phy as the t	W/W	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	me of preg	i laricy	etal death	_	pregnancy	23d. Date of deliv Month	ery Day Year
OX 6 ath cer attendi	Physician/Med	1 Yes 2 V No 9 Unkn	own 9 Unknown	t time of de	eath 5	Other (Specify)				
P.O. Box 68760, es that the death certificate be igned by the attending physici be detached for use as the buri	Phy	Part II. Other significant condition		th but not re	esulting in the	e underlying caus	e given in Part	I. 23e. Did	tobacco use contribute	to the cause of death?
, P.(res that signed be det	d by							1 Y	es 2 No 3 P	robably 4 🗹 Unknown
rds v requi	lete								opsy prior t	autopsy findings available o completion of cause of
Reco	Completed by							1 ✓ Yes	formed? death 2 No 1	
Division of Vital Records, la or Attending Physician: The law requiring a place of the above of the above of the law requiring the place of the place of the funeral director, page 2 should led in by the funeral director, page 2 should	Be	25. Was case referred to medical examiner?	Hospital:		1		Other4			2
of Vi Physi er this	2	1 Yes 2 No 27. Manner of Death	28a. Date of Inj (Month, Day,	ent 2	ER/Outpation 28b. Time of		njury at Work?		Residence 6 🗹 Ot	ner, Scene
ON C ending ath. or: Af	tion	1 Natural 5 Pendi	19 Fd 8/1/		Fd 9:	40 am ¹□	Yes 2 X	o unk	t was asph	vxiated
ViSi or Att or Att Orecte in by	Certification:	3 Suicide & X Could	28e. Place of I	njury - At h		reet, factory, offic	e building, etc.	28f. Location	(Street and Number or	Rural Route Number, City Cannon Ave
Di sspital hours a neral I	Cer	4 X Homicide 29a. Certifier 1 Certifying Physics	(0,000,1)	unk	× 10			Hage	rstown, MD	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical		vsician: To the best of national iner: On the basis of example 1	amination a	ige, death oc and/or investi	curred at the time gation, in my opin	, date and plac iion, death occi	e, and due to the ca urred at the time, dat	use(s) and manner as s re and place, and due to	the cause(s)
To wit To	Mec	29b. Signature and title of certifier	and manner stated	111	284	29c. Lice	ense number		29d. Date signed (Month, Day, Year)
		Vielo	ller de	el-	130	0.	C.M.E.		August 2, 2010)
		30. Name and address of person victor Weedn MD JD	who completed cause of Assistant Medica			Penn Street	Baltimore	MD 21201		
	tate	31. Date filed (Month, Day, Year)	Assistant Medica	ar's Signáti	ure z	. 0.111 011661	, Dakiniole			
		AUC 1 77 2010	6	has	ale					

10-05863 Darrell McCammon Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Darrell McCamr	non	1- For State	taleer Mufyiane		elle of I		d Menta		201	0 25697
Physici		1. Decedent's Name (First, Mid Darre11	dle,Last) Robert		Mad	Cammon		2. Date of De Month	Dav Year	3. Time of Death
Medical Exam	iner	4a. Facility Name (if not institut		1		. City, Town, or	Location of	August 5	7, 2010 4c. County of	0900 hrs
		616 Adams Avenue				Hagerstown	1		Washingto	on
Funeral Director		5. Social Security Number 219-66-2404	6. Sex 7. Ag	e (In yrs. last bir	rthday) Yrs.	If Under 1 Year Months Days		Min		9. Birthplace (State or Foreign Country) Maryland
any		Usual Residence of Decedent 10a. State 10b. County	,	10c. City, Town	or Location	1				10d. Inside City Limits
*	or	MD Wash	ington	Hage	erstov	√n				1 X Yes 2 No
h the Maryland 3a or 28a-f sh totified at ones	Director	10e. Street and Number	1.1			10f. Zip Code			10g. Citizen of What	
with th is 23a		140 W. Frank	12. Was Decedent	Ever in U.S.	13. Was	217 Decedent of His		n? (Specify Yes or N	U • S	· A · American Indian, Black,
21215-0036 Joint de filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f she c event, the Medical Ex. miner must be notified at once	Funeral	1 Never Married 2	Married Armed Forces?	X No				Puerto Rican, etc.)	White, e	
rs after ural",	by	Widowed 4 X D 15. Decedent's Education (Sp	ivorced If Yes, Give Year or Dates:	onleted) 16a		es 2X No		nd of work done	Specify:	White
3 72 hou n "nat	eted	Elementary/Secondary (0-12				t of working life.			TOD, KING OF BUSIN	less/maustry
21215-0036 build be filed within 72 hours at Mental Hygiene. marked other than "natural ic event, the Medical Examin	Completed	12		N	I/A				N/A	A.
1215-1 be filed ental Hyg irked oth	Be C	17. Father's Name (First, Middle Robert Earl Me	•			1		Name (First, Middle, e C. Spred	•	
212 hould b nd Men is marl	To E	19a. Informant's Name/Relation	ship (Type, Print)		b. Mailing A	ddress (Street			mber, City or Town,	State, Zip Code)
ore, MD s 1 and 2 sho of Health and If item 27 is		Natasha L. Mc	Cammon/Daught			Baltimon (Name of cem		t., Greend	castle, PA	
		1 Burial 2 X Crematic	_	ate cremat	tory or other	place)				,
Baltimore, permit. Pages 1 a Department of He Important: If ite		4 Donation 5 Other S 21. Signature of Funeral Service		Smith	22, Nar	Cremat ne and Address	ory of Facility	8/7/2010 Rest Have	Smithsl	ourg, MD
		S. Menk	Suga		160	1 Penns	ylvan:	ia Ave., I	Hagerstown	n, MD 21742
Physician /M di J		23a. Part I. Enter the disease, o failure. List only one cause	e on each line.				such as card	diac or respiratory ar	rest, shock, or heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conse	one Into	OXICAL	.1011				55561
	<u>ت</u>	Sequentially list conditions, if any, leading to immediate	b Due to (or as a conse	quence of):						
10	miner	cause. Enter Underlying Cause (Disease or injury that mitiateu								
My cuted with transit	Exa	events resulting in death) Last	d							
0, be execut sician and	edical	X UNPENDED	AMENDED 283	23a,27;	2 8a 7 f 9	725/26 1	8908	9-10-10 v	t	
876(tificate ng phy as the t	ΣI	IF FEMALE: 23b. Was decedent pregnant in t past 12 months?	he 23c. If yes, outcom	e of pregnancy	Fetal	death 3	Ectopic p	regnancy	23d. Date of de Month	ivery Day Year
Box 68760, ne death certificate be eath certificate be eath the attending physician bed for use as the buna	hysicia		4 Pregnant at the liknown 9 Unknown	time of death	Other	(Specify)				
that the d	4	Part II. Other significant condi	-	but not resulting	g in the und	erlying cause giv	ven in Part	J. 23e. Did to	obacco use contribut	e to the cause of death?
S, P.O. uires that the signed by id be detach	ed by							1Ye	s 2 No 3	Probably 4 V Unknown
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been siled in by the funeral director, page 2 should be	ompleted							24a. Was		re autopsy findings available r to completion of cause of
tal Rec	O	25. Was case referred to medica	n I			00.01	(B. () (0)	1 ✓ Yes		Yes 2 No
Vital Rechysician: The lathic certificate latricate latricate latricate latricate latricate latricator, page	o Be	examiner?	Hospital: 1 Inpatier	nt 2 ER/Ou	utpatient 3		thor -	heck only one) Jursing Home 5	Residence 6 🗸	Other: Scene
n of Jing Ph. After tl	i.i	27. Manner of Death	28a. Date of Injur (Month, Day,Ye	y 28b. 1	Time of Injui				how injury occurred	
Sior Attend r death. ector: by the	catic	2 Accident Inve	ding stigation fd 855	\mathbf{n}	7:05a		es 2 X No	unknow		D. al D. d. N. d.
Divipital or a spital or a sterior after prize in filled in the spital or a sp	Certification:		Id not be 28e. Place of Injiermined (Specify)	house house		actory, onice bu	nung, etc.	or Town, S	State)	r Rural Route Number, City Hagerstown, Md
Division of Vital Records, P.O. Box 6876. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the t	Medical C	1	hysician: To the best of my miner: On the basis of examand manner stated.					, and due to the caus	se(s) and manner as	stated.
E × E 3	₩.	29b. Signature and title of certific				29c. License			29d. Date signed	
		Lagar Brukhal	1. 110			O.C.M	I.E. 		August 6, 201	0
		30. Name and address of person Pamela E. Southall, N		, ,	r 111 F	Penn Street,	Baltimor	e, MD 21201		
	_			-						

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.	201	0	2
C Date of Double	,	1 2	Time of

-05524	rtuc	Please Typ	ate of Maryla	n Black in and / Dena	artment of	K. ⊑IIS Health	and	Menta	al Hva	iene	gibie	201	0	25698
c Charles Ma		1- For State	ate of Ivialyi	and / Depa Cei	rtificate of	Death	and	Wiente	ai i iyg		Reg. No.	201	U	23030
Physicia		Registrar 1. Decedent's Name (First, Middi	e,Last)		<u> </u>					Date of De	ath	Voor		me of Death
cal Exami		Eric Charles								Month I uly 24, 2	Day 2010	Year	30	800 hrs
		4a. Facility Name (if not institution			4	b. City, Tow			Death			County of De	ath	
		Molasses Road at Fo	untain School F	Road		Union B						rederick		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Months		If Under Hours	24Hrs. 8 Min.	B. Date of B	irth(MM/I	DD/YYYY) 9. Fo	reign	1
Director		218-78-8872	1_XM 2_F	4	9 Yrs.	Wiorius	Days	110015	1	May 2	0, 19	961	County)	aryland
	l	Usual Residence of Decedent											1104	Inside City Limits
v any		10a. State 10b. County			Town or Location									Yes 2 No
daryland 28a-f show datonce.	5	4	roll	Ne	ew Winds								-	<u></u>
ie Maryland or 28a-f sho <u>fied at once</u> .	Director	10e. Street and Number				10f. Zip Co					10g. Citiz	zen of What C		
a the Ba or		1178 Jo Apter	Place				L776					USZ		
ms 2.	Funeral	11. Marital Status)	cedent Ever in U orces?		Decedent s, specify C					lo-	14. Race - Ar White, et		ndian, Black,
death or ite	Fu	1 Never Married 2 M	1 Yes	2 X No		· · · ·	1				1	Specify:	White	_
s after ral", viner	by		vorced If Yes, Give Ye		16a. Decedent	Yes 2	_	specify:	ind of wor	k done		(ind of Busine		
hours natu Exan		 Decedent's Education (Spe Elementary/Secondary (0-12) 		1-4 or 5+)		st of working						tomac V		-
)36 thin 72 ne. than "	ple	Elementally/Secondary (0-12)	2	1 4 01 0 1	Physica	al The	erap	ist i	Assi	stant		orts Me		-
5-0036 iled within 77 Hygiene. d other than	Completed	17. Father's Name (First, Middle	, Last)									Surname)		
21215-00 uld be filed wit Mental Hygien marked other c event, the Ms	Be C	Peter Charl		ci				Dor	othy	McCo:	nvil	le		
21215-003 unld be filed withi Mental Hygiene, marked other th	To E	19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailing	Address	(Street	and Numb	er or Rur	al Route N	umber, Ci	ity or Town, S	tate, Zip f	Code)
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland near of Health and Menla Hygienei. The file of the Menla Hygienei. The file of the market other than "natural", or items 23a or 28a-fish or other traumatic event, the Medical Examiner must be notified at once	_	Michele Marie	Martucci/	Wife	1178	Jo Apt	er	Place	e.Ne	w Wi	ndsoi	r, MD	21776	5
e, hand I and Healt item	1	20a. Method of Disposition	The Action	20b.	Place of Disposi crematory or oth	tion (Name	of ceme	etery,		ate	20c. l	Location - Cit	or Town	n, State
nor ages ant of nt: If		1 Burial 2 Crematio		Ca:	rrol Cre	ematic	on I	nc.	07/26	5/201	0 Har	mpstead	a, Ma	aryland
Baltimore, MD 2 permit. Pages 1 and 2 shoul Department of Health and M Important: If item 27 is minjury or other traumatic		21 Signature of Funeral Service			22. N	ame and Ac	ddress c	of Facility	1 Hor	ne and	d Cha	apel, 1	P.A.	
Dep Peri		23a. Pirt I, Enter the disease, o	Je 3			112 Wa	shi	nato	n Rd	We	stmir	nster.	MD 2	21157
Physician		23a. Pirt I. Enter the disease, o failure. List only one cause	complications that	caused the death	n. Do not enter th	e mode of	dying, s	uch as ca	rdiac or re	espiratory a	irrest, sho	ock, or hear	Ap Br	proximate Interval etween Onset and
/Medical		Immediate Cause (Final disease	1-1	Sunshot Wou	ınd									Death
< Examiner		or condition resulting in death)	Due to (or as	a consequence of	of):								1	
	_	Sequentially list conditions,	b.	a consequence of	of):								-	
	ine	if any, leading to immediate cause. Enter Underlying Cause		a consequence v	01).						_			
	Examiner	(Disease or injury that initiated events resulting in death) Last		a consequence	of):									
executed an and al - transil							_							
be exe	dical	UNPENDED	AMENDED			<u> </u>								
Ox 68760, eath certificate be e attending physicia for use as the buria	cian/Med	IF FEMALE: 23b. Was decedent pregnant in		, outcome of preg		tal death	3	Ectopic	pregnano	v	23	 d. Date of del Month 	ivery Day	Year
certificanting	cial	past 12 months?	I LIVE	nant at time of d	anth -	her (Specif	_		F1-911-111	,				
Box 6 e death cer the attendi	. <u></u>	1 Yes 2 No 9 Ur	nknown 9 Unk	nown										
O.O. Ethat the done of the detached	Phy	Part II. Other significant condi	tions contributing	to death but not	resulting in the u	inderlying c	ause giv	ven in Par	rt I.		_			ause of death?
rds, P.(requires that been signed hould be det	d b													4 Unknown
ords, I w requires s been sig should be	<u>e</u>									24a. Wa	as an topsy			y findings available letion of cause of
e law te has	Completed										rformed? s 2 ✓ N	dea dea	th? Yes	2 No
Vital Rechysician: The this certificate		25. Was case referred to medic	al			26	.Place	of Death (Check on	ly one)				
/ita /sicial is cer direct	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatient	3 DO	A C	Other 4	Nursing	Home 5	Reside	ence 6 🗸	Other: Sce	ene
n of \ ding Phy After th funeral	-	27. Manner of Death	28a. Dat	te of Injury hth, Day,Year) D:	28b. Time of I	njury 28	Bc. Injury	at Work		8d. Descrit ubject s		jury occurred		
on endin ath. or: A	흘		nding estigation Jul 24		FOUND: 0630 hrs	İ	1 Y	es 2 🗸	No					
/iSi or Att her de hirect on by	<u>i</u>			ace of Injury - At	home, farm, stree	et, factory, o	office bu	uilding, etc		or Towr	(etets)			Route Number, City
Division pital or Attent ours after death neral Director: filled in by the	Certification:	4 Homicide det		y) Local Stre										ad, Union Bridge,
		29a. Certifier 1 Certifying	Physician: To be b aminer:On the basi	est of my knowle	dge, death occur	red at the t	ime, dat	te and pla	ice, and d	ue to the c	ause(s) ar	nd manner as lace, and due	stated.	use(s)
To the Hos within 24 h To the Fur completely	Medical		anormannei	s or examination r stated.	anuror investiga				ounou at			Date signed		
WIL	Įž	29b. Signature and title of certif	ier /			- 1		number			ı	y 25, 2010		cay, rodry
M10		/	/ (/				O.C.N	n.C.			Jui	, 20, 2010		
OCME		30. Name and address of person				1 Penn S	Street	Raltim	ore Mr	21201				
OUNE		Mary G. Ripple MD.	Deputy Chie			renns	ou eet,	Dalum	OIE, IVIL	/ 4 1 2 0 1				
Regi:	State	. 11 11 /	7 2010 32	Registrar's Signa		Kel								
	1.00				ORIGINA									
DHMH 17 Rev 1/	r2001					-								

		For State	State of Ma		partment of ertificate of			_ Z U I	0 25699
		Registrar 1. Decedent's Name (First, Middle,	Last)		ortinodio or	Dourn	2. Date of Death		3. Time of Death
Physic Med		Gloria Marsh					\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	1/ ² /2 ⁰ 10 [×]	9:15 _a M
Exam	iner	4a. Facility Name (if not institution, see Prince George			4b. City, Town, o	or Location of Death		4c. County of	Death e George
Funera	i	5. Social Security Number		In yrs. last birthda	y) If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth	9	Birthplace (State or Foreign
Directo	1	579-68-0466 Usual Residence of Decedent	IUM 2LA	9 Yrs	Worland Buys	Tiours Willi.	(Month, Day,) 09/25/	50	Washington,D
land show dat	ţ	10a. State 10b. County		10c. City, Town or					10d. Inside City Limits
e Mary r 28a-1 notifie	Sirec	Md Princ	e George	Capito	ol Heigh	ts ———			1X Yes 2 □ No
21215-0036 within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f show, the Medical Examiner must be notified at	Funeral Director	1101 Glen Wil	low Drive	#8	10f. Zip Code 207	43	10	ng. Citizen of What USA	at Country?
death v items		11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 1	3. Was Decedent of h	Hispanic Origin? (Spean, Mexican, Puerto			American Indian,
after all, or xamir	d by	1 ☐ Never Married 2 ☐ Marrie 3★️ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 N If Yes, Give	0	1 ☐ Yes 2 🛣 No			Specify:B	White, etc. lack
hours hatura	olete	15. Decedent			cedent's Usual Occu			6b. Kind of Busir	ness Industry
thin 7:	Completed	(Specify only highes Elementary/Seconday (0-12)	College (1-4 or 5+	life	ve kind of work done . DO NOT use retired ITSE		ing	Gover	nment
nd 2 filed wil al Hygie d other event, tt	Be	17. Father's Name (First, Middle, La	1 2+ st)	1 111	1136	18. Mother's Name	e (First, Middle, Ma	aiden Surname)	
	₽	John Henry W	atkins Jr			Ida Ma	e Robin	son	
Nore, Maryland ge 1 and 2 should be filed at of Health and Mental Hy : If item 27 is marked oth or other traumatic event		19a. Informant's Name/Relationship		19b. M 761	ailing Address (Street 5 Fontaine	and Number or Rura Bleau - Dr	al Route Number, C	City or Town, State	e, Zip Code)
7 7 7		Toya Colbert 20a. Method of Disposition	Daughter	20b. Place of Dis	Fontaine Carrolton	1.*	d20784	Oc. Location - Ci	ty or Town, State
Baltimore, Dermit. Page 1 and Department of Hes mportant: if item any injury or othe		1 🔀 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Sp		Glenwo	rematory or other pla odi Cemet	cery 08/0	03/10	Washing	gtom, DC
Baltimo permit. Page Department Important: I any injury o		21. Signature of Funeral Service Lic	rensee	0777	22.Sineadddi	Tufferal :	Home &		ion on,DC 20011
		23a. Part 1. Enter the disease, or construction shock, or heart failure. List on	omplications that caused t	he death. Do not e	nter the mode of dyir	ng, such as cardiac o	or respiratory arrest		Approximate Interval Between
Pnysician Medica		Immediate Cause (Final disease or condition resulting in death)	_a Fatal	Card	1ac Ar	rythm	LIA		Onset and Death
Examine		resulting in death)	Due to (or as a	consequence of):	1 Faile	ure,			
A - #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	b. Due to (or as a d	consequence of):		- (a She	,	
ecutec and I-transi	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Peru	consequence of):	ncepno	i Cop	RIVIL	1	
rate be executed physician and the burial-transit	edical		d.	,			-	6	
56/5 rertificate religing physe as the		IF FEMALE;						_	
BOX 6 death cer ne attendi ed for use	cian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at t	Fetal death	B	су		23d. Date of Month	,
the de	hysi	1 Yes 2 No 9 Unknown	9 Unknown		o El Other (Speciny) _				
S, F.S	Completed by Physician/M	Part II. Other significant condition	s contributing to death but	not resulting in th	e underlying cause gi	iven in Part I.		acco use contribu s 2 □ No 3 l	ite to the cause of death?
HECOLOS, The law requires ate has been signage 2 should b	plete	HUDETERSIO	n				24a. Was an		re autopsy findings available
The la arte ha	Com	Diabetes					autopsy performe 1 ☐ Yes 2	ed dea	r to completion of cause of th? Yes 2 \(\sum \) No
VITAI ysician: s certific director,	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		1011	lace of Death (Check	only one)		= //
OT V ig Phys ter this neral di	e: To	27. Manner of Death	28a. Date of injury	t 2 ER/Outpar 28b. Time	of 28c. Injur	4 □ Nursing Hory at	me 5 🗌 Residen 28d. Describe how		Specify)
ION tendin leath. or: Aft the fur	Certificate:	Natural 5 Pending 2 Accident Investiga 3 Suicide 6 Could no		<i>(ear)</i> injur		K? Yes 2 □ No			
LIVISION al or Attendin s after death. Il Director: Af		4 ☐ Homicide determin		- At home, farm, : Spec <i>ify)</i>	street, factory, office		28f. Location (Stre City or Town,		r Rural Route Number,
LIVISION OF VITAL RECORDS, F.O. BOX 08/17 to the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Medical	(Check 2 L. Medical Exa	Physician: To the best of maminer: On the basis of exalurse Practioner: To the be	mination and/or inv	estigation, in my opini	on, death occurred at	the time, date and	place, and due to	the cause(s) and manner stated.
To the	2	29b. Signature and title of certifier	er and the second of the secon	Storing knowledg	29c. Licens			d. Date signed (M	
2		· W59	9		DOC	4366	2	1/26/	2010
		30. Name and address of person with will came in the control of th	oyce 3	001 HO.	Spural C	DRIVE!	here	1/4 M	D 20785
Sta Regist		31. Date filed (Month, Day, Year) JUL 30 2	32 Registrar's	Signature	arked				

rease Type of Time in Black indensite ink.	Lisure An Copies Are Legiple.	
State of Maryland / Department of He	ealth and Mental Hygiene 2 []	

Aaron Robert Mard	1- For State	state of Maryla		artment of rtificate of		Mental F	7.0	201	0 25700
Physician/ Medical Examine			arders				2. Date of Dea Month August 7,	Day Year	3. Time of Death 0409 hrs
}	4a. Facility Name (if not institute 550 Gorsuch Road			4	b. City, Town, or L Westminster			4c. County of	
Funeral Director	5. Social Security Number	6. Sex	7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24Hr Hours Min	n.	th(MM/DD/YYYY)	9. Birthplace (State or Foreign
any	216-17-1155 Usual Residence of Decedent 10a. State 10b. Count		34	Yrs. Town or Locati			July .	15, 1976	Country) MD
	MD Car	roll	, soc. only,	Westmi	nster				10d. Inside City Limits 1 XYes 2 No
ith the Maryland 23a or 28a-f show notified at once.	10e. Street and Number 550 Gorsu	ıch Rd.			10f. Zip Code 211	57	1	0g. Citizen of Wha	t Country?
or items		Married 12. Was Deci Armed Fo 1 Yes ivorced If Yes, Give Year or Dates:	2x No	If Ye	s Decedent of Hisp es, specify Cuban, Yes 2 X No	Mexican, Puerto		American Indian, Black, etc. Whit e	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner. To Be Completed by I	15. Decedent's Education (Sp Elementary/Secondary (0-12	ecify only highest grad		during mo	s Usual Occupationst of working life, [on (Give kind of DO NOT use ret	work done ired)	16b. Kind of Busin	ness/Industry VieW
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	17. Father's Name (First, Middle Farl Marders					Patric	ia Carol	Nursing Maiden Surname) Richter	
MD 21 d 2 should th and Me n 27 is ma umatic or	19a. Informant's Name/Relation	, , , , ,	her		Address (Street a	and Number or	Rural Route Num tminster	ber, City or Town,	State, Zip Code)
Baltimore, MC permit. Pages I and 2 s Department of Health an Important: If item 27 injury or other traums.	20a. Method of Disposition 1 Burial 2 Crematic	n 3 Removal fro	m State 20b. P	Place of Disposit rematory or other	ion (Name of ceme er place)	etery,	Date	20c. Location - C	ity or Town, State
Baltimo permit. Pag Department Important; injury or ot	4 Donation 5 Other S 21. Signature of Funeral Service		St.	22. Na	Cemeter	of FacilityPri	0/2010 tts Fune	eral Home	ad, Maryland & Chapel, PA
Physician /Medical Examiner	23a. Forth. Enter the disease, of failure. List only one cause Immediate Cause (Final disease	on each line.		Do not enter the	2 Washing e mode of dying, su ating Di	uch as cardiac o	or respiratory arre		D 21157 Approximate Interval Between Onset and Death
) Examiner	or condition resulting in death) Sequentially list conditions,	Due to (or as a ob.	consequence of)):					
ted Instit Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c							
be executed sician and unial - transi	X UNPENDED	d AMENDED	23a,27	per me	g908 10-	-13-10 v	/t		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit edical Certification: To Be Completed by Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in t past 12 months? 1 Yes 2 No 9 Un	he 1 Live bir	nt at time of dea	2 Feta	I death 3	Ectopic pregna	incy	23d. Date of de Month	livery Day Year
ires that the d signed by the be detached	Part II. Other significant condi			sulting in the un	derlying cause give	en in Part I.		pacco use contribut	e to the cause of death? Probably 4 Unknown
Records, The law requirer ficate has been sig , page 2 should bu							24a. Was a autops perforr	y prior ned? deat	e autopsy findings available r to completion of cause of th? Yes 2 No
Vital Recysician: The bis certificate director, page	25. Was case referred to medical examiner? 1 ✓ Yes 2 No	Hoopital: ===	patient 2 E	ER/Outpatient		Death (Check of		Residence 6 🗸	
ion of Vi tending Physi eath. tor: After this the funeral dir	27. Manner of Death 1 X Natural 5 Pend	28a. Date of (Month, Date)	f Injury Day,Year)	28b. Time of Inju	ury 28c. Injury a			ow injury occurred	
Division o To the Hospital or Attending within 24 hours after death. To the Foureral Director: Afte completely filled in by the fune edical Certification:	3 Suicide 6 Coul 4 Homicide		of Injury - At hon	ne, farm, street,	factory, office build	ding, etc.	28f. Location (St or Town, Sta		r Rural Route Number, City
To the Hos within 24 h To the Fur completely	one) 2 Medical Exa	hysician: To the best of miner:On the basis of and manner sta	examination and	e, death occurre	n, in my opinion, de	eath occurred a	due to the cause t the time, date a	(s) and manner as nd place, and due t	stated. to the cause(s)
) d ≥	29b. Signature and title of certific	e Youll			29c. License n			August 7, 201	
Marie 1	 Name and address of person Margarita Korell MD. 	who completed cause Assistant Medic	•		nn Street, Balti	imore, MD 2	21201		
State Registrar	31. Date filed (Month, Day, Year)		trar's Signature	A. 400	aked				

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2<u>010</u> Physician/ July 26 0730 McDaris Mae Anna Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Finksburg 3887 Sykesville Rd. If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min. Months 1 M 2 TXF June 4, 1927 West Virginia Yrs. Director 83 236-40-0656 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Carroll Finksburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21048 3887 Sykesville Rd 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates 3 Widowed 4 X Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Arlington Mortgage, Co. Clerical Office Work 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ traumatic Willie Lee Grace Hazelwood Wheeler H. Fields 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau 21048 <u>3887 Sykesville Rd.</u> Finksburg, MD Robin Hill Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 X Removal from State 7/30/2010 Falls Church, VA National Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facilipritts Funeral Home & Chapel, PA - V 412 Washington Rd. Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or a PREssure hydrocephalus attending physician and for use as the burial-trans that initiated events resulting in death) Last Physician/Medical that the death certificate be IF FEMALE: Live Birth 2 Fetal death 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perfor Yes 2 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: ဂ္ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Director: After Hospital or Attending 1 Natural 2 Accident work?
1 Yes 2 No 5 Pending Investigation filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined after City or Town, State) within 24 hours a

To the Funeral D

completed filled i Medical 1 🔀 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2. only one) 29b. Signature and WIL and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Security

Registrar

Maryland 21215-0036

3altimore.

68760

Box

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Lori Ann Metzger July 2010 10:15 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Westminster Carroll 5. Social Security Numbe 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)

PA 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, May 4 1 □ M 2 🙀 F Days 50 ^{Year)} 1960 Director 195-56-6211 Usual Residence of Decedent shov 10a. State 10c. City, Town or Location must be notified at 10d. Inside City Limits Director MD Carroll 28a-f Westminster 1 Yes 2X No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 335 Stoner Ave. 21157 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. the Medical Examiner Black, White, etc. \$ 1 Never Married 2 Married Yes 2 No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ੌ No Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Retail Manager Hickory Stick Be 17. Father's Name (First, Middle, Last) Charles K. Metzger 18. Mother's Name (First, Middle, Maiden Surname) Anite Olive Michael Should be filed hand Mental H ris marked ot permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Philip R. Boob, Jr. - Husband 335 Stoner Ave., Westminster, MD 21157 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Carroll Cremation, inc. 7/26/2010 Hampstead, MD 21. Signature of Funeral Service Licensee 22. Name and Address of FaciliPritts Funeral Home & Chapel, PA 412 Washington Rd., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on eath line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) sician and burial-transit Exami Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year ate has been signed by the page 2 should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 1 Yes 2 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ☐ (Spice 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of within 24 hours after death.

To the Funeral Director: After t
completed filled in by the funera Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the 1 within 2 To the 5 29b. Slanatur 29c. License number WIL 12 completed cause of death (Item 23a) (Type, Print) Ler Street (1) Estriuster, MD 2/157

Registrar DHMH 17 Rev 7/2009

State

Division of Vital

			24 LM.	artment of Health and Mertificate of Death		ene 2010 25703						
	Physicia	ın/	Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death						
	Medic	cal	Jacob Paul Nairn		August	3 2010 0105 AM						
	Examir	er	4a. Facility Name (if not institution, give street and number) Washington County Hospital	4b. City, Town, or Location of Death Hagerstown	0	4c. County of Death Washington County						
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9 Rirthplace (State or Foreign						
	Director		182-14-0791 1	Months Days Hours Min.	(Month, Day, Ye Aug. 21,	1922 Maryland						
	and show 1 at	ō	10a. State 10b. County 10c. City, Town or Lo	cation		10d. Inside City Limits						
	Maryl 28a-f otified	Director	Maryland Washington County Hagerstow	m		1 ☐ Yes 2 💢 No						
	th the 3a or the n	a D	10e. Street and Number 1124 Fairview Rd.	10f. Zip Code		g. Citizen of What Country?						
	ems 2	Funeral	11 Market Chatter 12 Was December From in LLC 12	21742 Was Decedent of Hispanic Origin? (Speci		J. S. A. 14. Race - American Indian.						
9	ter de , or it	by F	1 ☐ Never Married 2 ☐ Married	f Yes, specify Cuban, Mexican, Puerto Ri	ican, etc.)	Black, White, etc.						
Ö	within 72 hours after death with the Maryland giene. et than "natural", or items 23a or 28a-f sho t, th- M. dical Examiner must be notified at	Completed	1944 Teal of Dates. 1944	1 ☐ Yes 2 💢 No Specify:		Specify: White						
75	72 ho an "na Madio	m ple	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working O NOT use retired)	16	b. Kind of Business Industry						
212	withir giene ner th: t, the		College (1-4 or 5+)	neer	W	lire Rope Mfg.						
and	l be filed fental Hy rked oth tic event	To Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (
ary!	should be and Me is mark aumatic		Alphonse A. Nairn 19a. Informant's Name/Relationship (Type, Print) 19b. Maili	rne Nairn ty or Town, State, Zip Code)								
ž	and 2 sh Health ar tem 27 is ther trau			Woodland Way Hage		MD 21742						
_			20a. Method of Disposition 20b. Place of Dispo			c. Location - City or Town, State						
ti Ei	permit. Page 1 Department of Important: If it any injury or conce.		4 □ Donation 5 □ Other (Specify) Rest Have	en Cemetery 8-7-2	010 Ha	gerstown, Maryland						
Ba	permit. Departn Importa any inju	0		. Name and Address of Facility Doug .331 Eastern Blvd.		Fiery Funeral Home						
			23a. Part 1. Enter the disease, or complications that caused the death. Do not ent- shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac or r	respiratory arrest,	Approximate						
4	nysician/	3 /4	Immediate Cause (Final disease or condition	edial my	enci	Interval Between Oriset and Death						
J	Medical Examiner		resulting in death) Due to (or as consequence of):	alor Ole	0. 11	1400 1400						
		ner	Sequentially list conditions, if any leading to immediate the conditions of the cond									
	nd ransit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events c.	ue acal	9-821	2 . Hons						
_	ite be executed hysician and he bunal-transit	dical E	resulting in death) Last Due to (or as-a consequence of):	2 Jibn'll	2 Azon	n Your						
	을 줄은 [ledic	d. Ovolu) /CIO O I CIC	1620	1 /200						
89 ×	attending p	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐	Ectopic pregnancy		23d. Date of delivery						
Box	y the atter	Physician/Me	1 Yes 2 No 9 Unknown Unknown Time past 12 No 9 Unknown Time of death 5 1 Yes 2 No 9 Unknown 1 1 1 1 1 1 1 1 1			Month Day Year						
	gued	þ	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part !./	23e. Did tobacc	co use contribute to the cause of death?						
Vital Records,	been sign	Completed	(C) (a) (C)	of prinace		2 No 3 Probably 4 Unknown						
00 E	has e 2	Idmo		04100	24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?						
e e	certificate rector, pag		25. Was case referred to megical	26. Place of Death (Check or	1 Yes 2	1 ☐ Yes 2 ☐ No						
X	his cer I direc	10 E	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien	t 3 DOA Other: 4 Nursing Home	e 5 🗌 Residence	e 6 🗆 Other (Specify)						
Division of	h. After ti funera	ate:	27. Manner of Death 1	work?	d. Describe how in	njury occurred						
SIO	r deat	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined determined	M 1 ☐ Yes 2 ☐ No eet, factory, office 28	If. Location (Street	t and Number or Rural Route Number,						
<u> </u>	al Dire		building, etc. (Specify)		City or Town, St							
100	within 24 hours after death. To the Funeral Director. After this certification of the funeral director, it is completed filled in by the funeral director, it is a second of the funeral director.	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of my knowledge, death of the be	igation, in my opinion, death occurred at the	e time, date and pl	ace, and due to the cause(s) and manner stated.						
÷	With Com	_	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day) Year)						
			30. Name and address of person who completed cause of death (Item 23a) (Type, E	x Q0 4302	e a	MB 21740.						
5H	9+1		54A437 SIDERCUL 324 C	aulietan 8	HAC	SU MD 21740.						
	State Registra		31. Date filed (Month, Day, Year) 6 2010 32. Pegistrar's Signature	all								

		For State	State	of Marylan	-	rtment of H		l Mental Hy	_	0.1.0	05701	
		Registrar 1. Decedent's Name (First, Middle, L	aet)		Cer	tificate of D	Death	T	Reg. No.	010	25/04	
Physicia Medi		Maryellen Nisse	,					2. Date of De Month	eath Day	2010	3. Time of Death A	
Examir		4a. Facility Name (if not institution, g	ive street and nur			4b. City, Town, or	Location of Dea					
1 =	F	Washington Coun	ty Hospi	tal 7. Age (In yrs. Ia	and friedfactors	Hagersto	OWN If Under 24 Hr	- los: '/a			County	
Funeral Director		148-16-4755	1 □ M 2 🂢 F	82	Yrs.	Months Days	Hours Mir		rth a <i>y, Year)</i> 28 - 1 9	Coun	place (State or Foreign try) U Jersev	
nd now	Ļ	Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Loc	ation		7-10-2			0d. Inside City Limits	
farylar 3a-f sl tified	ecto	Maryland Washing	ton Cour		lagerst]"	1 ☐ Yes 2 🏹 No	
the Manager 2018	٥	10e. Street and Number				10f. Zip Code			10g. Citizer	n of What Coun		
th with ms 23 must	iner	309 Kingswood T				21742				S.A.		
or itel	by Funeral Director	11. Marital Status1 ☐ Never Married 2 ☐ Married	Armed Fo	edent Ever in U.S rces? 2 X No		as Decedent of His Yes, specify Cubar	spanic Origin? (\$ n, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		Race - Americ Black, White, e		
5-UU36 2 hours after "natural", o dical Exam		3 XWidowed 4 ☐ Divorced	If Yes, Giv Year or Da	'e	1	☐ Yes 2 🔀 No	Specify:		Spe	ecify: Wh	ite	
72 ho n "nat	Completed	15. Decedent's (Specify only highest	Education grade completed,		(Give k	ent's Usual Occupa ind of work done do NOT use retired)	ition uring most of we	orking	16b. Kind	of Business Inc	dustry	
IIG Z IZ ID-UU30 filed within 72 hours after death with the Manyland al Hygiene. d other than "natural", or items 23a or 28a-f sho went, the Medical Examiner must be notified at	S	Elementary/Seconday (0-12)	College (1	-4 or 5+)		naker			Perso	onal Re	sidence	
ine, Marylaild ZIZIS-UU30 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Las	t)				18. Mother's Na	ame (First, Middle,	Maiden Surr	name)		
should b and Mer is mark aumatic	ļ-	WIIIIam Effect Julia Sullivan Fhi										
e, Mc and 2 sh Health ar tem 27 is		Marcia Nissel	p (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town 13308 Apple Hill Dr. Hagerstown, MD									
Page 1 and nent of Heal ant: If item 3 ury or other		20a. Method of Disposition 1 X Burial 2 □ Cremation 3	☐ Removal from	20b. P	lace of Dispos	ition (Name of atory or other place		Date		ion - City or To		
permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other:		4 Donation 5 Other (Spe	ecify)	Re		en Cemete		-2010			Maryland	
permit. Departn Importa any inju		21. Signature of Funeral Service Lice	Haron	1 Sut	L 1	Name and Address	s of Facility $$ $$ $\!$ $\!$ $\!$ $\!$ $\!$ $\!$ $\!$ $\!$ $\!$ $\!$	ouglas A . Hagers	. Fier town.	y Fune MD 217	ral Home 42	
		23a. Part 1. Enter the disease, or co shock, or heart failure. List only	mplications that of one cause on ea	caused the death ch line.		the mode of dying	, such as cardia				Approximate Interval Between	
Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)		Onset and Death								
Examiner		Company to the tipe of the control o	R	or as a constru	oir v	Failur	e e					
g t	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due 5	or as consequ	ence f):							
xecute n and al-trans	Exar	that initiated events resulting in death) Last	c. Due to	or as a consequ	ence of):					_		
Attending Physician: The law requires that the death certificate be executed a death certificate be executed an edge. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	edical		■ d									
ertificat ling ph e as th	/Mec	IF FEMALE:	00 - 15									
ath certific attending p	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live I	come of pregnar Birth 2 Fetal nant at time of d	Ideath 3 🗌	Ectopic pregnancy Other (specify)			23d.	. Date of delive Month	ry Day Year	
hat the deed by the detached	hysi	9 Unknown	9 🗆 Unkn									
res that signed	þ	Part II. Other significant conditions	contributing to de	eath but not resu	alting in the un	derlying cause give	n in Part I.				e cause of death?	
requires t been sign should be	letec							24a. Was			ably 4 X Unknown sy findings available	
The law ate has page 2 :	Completed							autor perfo	osy ormed?	prior to con death?	npletion of cause of	
ician: The certificate ector, pag		25. Was case referred to medical examiner?				26. Plac	ce of Death (Che	1 L Yes	2 X No	1 Yes	2 LI NO	
Physi this c	욘	1 Yes 2 X No 27. Manner of Death	Hospital:	Inpatient 2 I	ER/Outpatient 28b. Time of		4 ∐ Nursing I	Home 5 - Resid				
nding ath. r: After	icate	1 Natural 5 Pending 2 Accident Investigation	(Mont	h, Day, Year)	injury	28c. Injury a work? M 1 🗆 Y	es 2 🗆 No	28d. Describe h	ow injury occ	curred		
or Atte frer de irecto n by th	Certificate:	3 Suicide 6 Could not 4 Homicide determined	28e. Place	of Injury - At hor	me, farm, stree	t, factory, office		28f. Location (S City or Tow		mber or Rural F	Route Number,	
spital o		29a. Certifier 1 Certifying Ph	veician: To the h	et of my knowle	odge death or	cured at the time.	tate and place	1				
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	(Check 2 Medical Exar only one) 3 Certifying Nu	niner: On the basi	s of examination	and/or investic	lation, in my opinion	 death occurred 	at the time date a	nd place, and	due to the caus	se(s) and manner stated	
To t with To t		29b. Signature and title of certifier				29c. License r	number			gned (Month, D		
	-	30. Name and address of person who	completed cause	of death (Item)	23a) (Type P-1		8267		81	7/10		
3H-8		William Sn, 1	1110 Med	ical Cun	pu K	land, suit	c 127/1	la genstou	~4,1	10 212	41	
Stat Registra	_	31. Date filed (Month, Day, Year) AUG 0 6	2010 32. R	gistrar's Signatu	irė	and a						
								_				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 26^{ay} PATSY ANNE NYGAARD JULTY 20省份 4:30 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 15228 GANLEY ROAD BOYDS MONTGOMERY 5. Social Security Number If Under 1 Year 7. Age (In vrs. last birthday) If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Days Hours Months 05/18/1930 Director 230-36-0066 Yrs 80 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified as 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits MONTGOMERY BOYDS MD 1 ☑ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15228 GANLEY ROAD 20841 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No 3 Divorced Completed Specify: WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOUSEWIFE DOMESTIC 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ CLAUDE HAHN CLARA WILSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15228~GANLEY~ROAD, BOYDS, MD 20841MAURICE NYGAARD/SPOUSE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State BOYDS CEMETERY 07/29/2010 BOYDS, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility P.O. BOX 86 HILTON FUNERAL HOME BARNESVILLE MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final 10V/e Physician/ disease or condition Medical resulting in death) Examiner YRABS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examin LENSION YEABS Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and Il-tran resulting in death) Last Due to (or a consequence of) attending physician at for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Dav Year , the a signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Completed 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 2 🗆 No 1 Yes Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 XNO Other: 1 Yes ဂ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending work? 2 No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check

24 hours after death.

Funeral Director: After this within 2.

> State Registrar

only on 29b. Signate

JOSE

31. Date filed (Month, Day,

re and title of certifier

30. Name and address of person

2040

40588

29d. Date signed (Month, Day, Year)

SenecA Meadows PARKWay, MD 208

2010

GERMAN 1011

Certifying Nurse Practioner: To the best of my knowledge

LEON

who completed cause of death (Item 23a) (Type, Print)

ARDIO

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Box 68760

P.O. I

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle | ast) 2. Date of Death 3. Time of Death Year/C Day 3 / Physician/ Month 1409 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Columbia If Under 1 Year 8. Date of Birth
(Month, Day, Year)
2 //-i/41 5. Social Security Number 6 Say 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Min Hours 10M 2 | F Washington, DC 68 Director 216-38-5245 Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Yes 2 No West Friendship Maryland Howard 10e. Street and Number 10g. Citizen of What Country? Funeral 2701 Pfefferkorn Road 21794 United States 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Black, White, etc. Armed Force 1 Never Married 2 Married "natural", or þ Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Specify: 3 Widowed 4 X Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Engineer Electronics Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve မ Harry Sinclair Oliver, Sr. Lillian Cimera 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harry Sinclair Oliver, III/son 5956 Augustine Avenue Elkridge, Maryland 21075 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Final Journey Crematory 8/2/2010 Woodbine, Maryland 4 Donation 5 Other (Specify) ture of Funeral Service Lice Going Home Cremation Service P.O. Box 784 M00957 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Examir sician and burial-transit that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last ng physician as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Year Pregnant at time of death detached g 🗌 Unknown ģ Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has performed Yes 2 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Hospital or Attending 1- Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier DEA > BB9900970

Registrar DHMH 17 Rev 7/2009

State

12

Box 68760

P.O.

of Vital

Division

H. C-C.H

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shahas

31. Date filed (Month

Bavani

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10-05583 Edward Montesino- Ortiz State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3 Time of Death Month Day July 26, 2010 **Medical Examiner** Edward Montesino Ortiz 0047 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 11169 Columbia Pike Silver Spring Montgomery If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (in yrs. last birthday) **Funeral** 10/04/1981 Foreignuerto Rico 584-93-8905 28 Min. Director 1 X M 2 F Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Silver Spring Yes 2 X No MD Montgomery 28a-f shov Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country notified at USA 20901 11169 Columbia Pike 23a Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Race - American Indian, Black, or items If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
Puerto Rican White etc. White Armed Forces? Never Married 2 Married 2 X No Yes 4 X Divorced 3 Widowed If Yes, Give Year No Specify: 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life, DO NOT use retired) Elementary/Secondary (0-12) l Mental Hygiene. marked other than "ric event, the Medical E College (1-4 or 5+) Detailer Auto MD 21215-0036 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Eudes Montesino Liduvina Ortiz 19a. Informant's Name/Relationship (Type, Print) Sister
Montesino Ortiz, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HC 03 Box 11785 Corozal, Puerto Rico 00783 Health and Nitem 27 is n Baltimore, N 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place)
Municipal Cemetery8/7/2010 Corozal, Puerto Rico X Removal from State 1 X Burial Cremation tment of I on 5 Other Don: PATTITO O RIWALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md2091 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a. Part I. Ent Physician failure. List only one cause on each line Between Onset and /Medical Death a. Gunshot Wound to the Neck Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner Enter Discertair Courses (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical UNPENDED AMENDED the attending physician To the Hospital or Attending Physician: The law requires that the death certificate be twithin 24 hours after death.

To the Funeral Director: After this certificate has been stoned by the submarian advanced. Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed be ģ 1 Yes 2 ✔ No 3 Probably 4 Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? . death? 1 🗸 Yes ✓ Yes 2 No No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other₄ Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene 1 V Yes 28a. Date of Injury Jul 26, 2010 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject shot Natural 0035 hrs Director: 5 Pending Yes 2 V No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) IFO 11169 Columbia Pike, Silver Spring, Md. (Specify) In front of residence 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. g 2 W Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 26, 2010 110 30. Name and address of person who completed cause of death (Item 23a)

Registrar

DHMH 17 Rev 1/2001

OCME 2006

Ana Rubio MD.

31. Date filed (Month, Day Year

Assistant Medical Examiner

2. Registrar's Signature

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 07/28/2010 Juanita M. O'Neal 6:41 p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Asbury-Solomons Nursing Center Solomons Calvert Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 235-28-8745 Hours Min. 0992471922 Director Usual Residence of Decedent items 23a or 28a-f shov er must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director MD Calvert Solomons 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20688 11740 Asbury Circle, Apt 1508 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. n "natural", or item ledical Examiner n 14. Race - American Indian, Armed Forces?

1 K Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 XX Married 1 ☐ Yes 2 No Specify: White Specify: 3 Widowed 4 Divorced Completed Ith and Mental Hygiene.

27 is marked other than "nature traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be flik Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve ပ Earl Norris Hazel Ewing 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Scott E. O'Neal/Husband 11740 Asbury Circle, Apt 1508, Solomons MD 20688 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Arlington Nat. Cem 09/14/2010 Arlington, VA 4 Donation 5 Other (Specify) 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 21. Signature of Funeral Service Licenses J. Goff Blvd. Owings. art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Cevelorovascular Accident Physician/ disease or condition resulting in death) Medical Examiner Is dienic Coodin Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) sician and burial-transit Exami Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical that the death certificate be IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 🔀 No Month Year Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by The law requires 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 ☐ Yes 2 🖾 No within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 I 4 X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 1 X Natural 5 Pending 1 🗌 Yes 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) City or Town, State: Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within To the 29b. Signature and title of certifier

dew 5

Baltimore, Maryland 21215-0036

68760

P.O.

of Vital Records,

Division

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

JUL 30 2010

Acres 8. Lace

30. Name and address of pason who completed cause of death (Item 23a) (Type, Print)

David Tardio, M.D.

1610

14090 Solomons Island Road South, Suite 2500, Solomons, MD 20688

27,2010

		A	amend Item 29d p	ase Type or Prefer Phy. 07/ State of N	int in 30/10 //arylan	Black II Carro d / Depa	ndelible In	k. Ens W j T Health	sure All Cop and Mental	p <mark>ies Ar</mark> Hygien	re Legib	le.	05710
			State Registrar				rtificate of			Reg. N	7 0 1	U	25710
	Physicia	ın/	1. Decedent's Name (First, Middle						2. Date Mont	of Death h [ear	3. Time of Death
٠.	Medic Examin		Warren Theodo 4a. Facility Name (if not institution						of Death		0 201		12:55 A M
	, LABIIII	CI	Carroll Luthera			care	Westm				c. County of Carr	oll	
	Funeral Director		5. Social Security Number 099-24-2190 Usual Residence of Decedent	6. Sex 1 X M 2 □ F	ge (In yrs. Ia 80	ast birthday) Yrs.	If Under 1 Year Months Days	If Under Hours		of Birth 25 ay, Yeg	9	York	
	land show dat	tor	10a. State 10b. County		10c. City	y, Town or Lo			-			100	d. Inside City Limits
	• Mary • 28a-f notifie	Director		roll	<u></u>	Westminster						1 ☐ Yes 2 🔀 No	
	th with the ms 23a or must be r	Funeral D	10e. Street and Number 103 St. Paul (158			Ditizen of What		y?
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Married 2★ Mar 3 ☐ Widowed 4 ☐ Divorced	K Van Ohio	?	1	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2🌠 No	an, Mexica	igin? (Specify Yes o n, Puerto Rican, etc :	r No- .)		Americar White, etc Whit	D
15-(72 hou n "nat Aedica	Completed	(Specify only highe	nt's Education est grade completed)		(Give	dent's Usual Occup kind of work done	durina mos	st of working	16b.	Kind of Busin	ess îndu	stry
212	within giene. er tha , the N		Elementary/Seconday (0-12)	College (1-4 or 4	5+)	Elec	o NOT use retired) ctrical E	ngine	eer	W	<i>l</i> esting	hous	se
Maryland	e filed Ital Hy ed oth event	To Be	17. Father's Name (First, Middle, I William C. H						ner's Name (First, Mi	,	n Surname)		
Ž	d 2 should bath and Mer 27 is mark r traumatic		19a. Informant's Name/Relationsl			10b Mailir	a Addraga /Stract		neresa Bul		or Town State	Zin Co	
ž.	nd 2 sh ealth ar n 27 is er trau		Geraldine O'Rei		19b. Mailing Address (Street and Number or Rur 103 St. Paul Ct., West						de)		
Baltimore,	ge 1 an nt of He :: If item or othe		20a. Method of Disposition 1		e C	emetery, cren	sition (Name of natory or other pla		Date		Location - Cit	•	
alti.	mit. Pa bartme bortan injury		4 ☐ Donation 5 ☐ Other (S 21. Signature of Funeral Service L		Çarr				08/02/20		_		
m	permi Depar Impo any ir	i i	· Ma	M			Pritts F 412 Wash	unera	Home ar	nd Cha estmin	pel, F ster,	A. MD 2	21157
4	hysician/	0 4	23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition	complications that cause only one cause on each lin	ed the death ne. Me (n. Do not ente	er the mode of dyir	ng, such as	cardiac or respirato	ery arrest,		A	Approximate nterval Between ns t and Death
	Medical Examiner		resulting in death)	Due to (or as	a consequ	ence of):							
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury										
	executed lan and irial-transit	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c. — Due to (or as	a consequ	ience off:						_	
	cate be exe physician s the burial		resulting in death, cast	d.	a consequ	ence on.							
9876	rtificate ling phy e as the	/Med	IF FEMALE:	00.1/			_			1			
. Box 68760	Ine law requires that the death certificate be ate has been signed by the attending physic page 2 should be detached for use as the bu	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant 9 Unknown	2 Feta at time of d	Ideath 3	Ectopic pregnand Other (specify)	су		_	23d. Date o Month		ay Year
P.O.	s that to gned by se deta	by Pl	Part II. Other significant condition	ns contributing to death	but not resu	ulting in the u	nderlying cause gi	ven in Part	I. 23e.	Did tobacco	use contribut	e to the	cause of death?
rds,	v requires that is been signed be should be deta									1 ☐ Yes 2	2 1 No 3 [Probal	bly 4 🗆 Unknown
	sician: The law r certificate has b irector, page 2 sf	Completed								Was an autopsy performed? Yes 2	prior deat	to comp	y findings available bletion of cause of
Ita I	sician certifi irector	m l	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:			Oth	041	th (Check only one)				<u> </u>
_ 0	ig Phys ter this neral dir	te: To	27. Manner of Death	28a. Date of inj	ury	ER/Outpatien 28b. Time of injury	28c. Injur	y at	ursing Home 5 🗌	Residence ibe how inju		pecify)	
<u>0</u>	Attending Physician: ar death. ector: After this certific by the funeral director,	Certificate:	1 Natural 5 Pendin 2 Accident Investig 3 Suicide 6 Could	gation not be				Yes 2] No				
Division of Vital	Io the Hospital or Attendi within 24 hours after death To the Funeral Director: A completed filled in by the fr		4 Homicide determ	ined 28e. Place of In building, e	tc. (Specify)		eet, factory, office		City o	r Town, Stat			oute Number,
:	e Hosp 124 ho e Fune eleted fi	Medical	(Check 2 L Medical E	Physician: To the best o xaminer: On the basis of Nurse Practioner: To the	examination	and/or invest	igation, in my opinic	on, death or	ccurred at the time d	late and place	e and due to	the cause	e(s) and manner stated.
:	vithir To th		29b. Signature and title of certifier				29c. License		place, alterate		ate signed (M	onth, Da	y, Year)
	MIL		Nath 90	- MD				58	137	=	7/291	10	7/30/10
	10		30. Name and address of person v		death (Item	23a) (Type, P		307	Work.	nnch	/ N	10	2(157
	Stat Registra	9	31. The filed (Month, Day, Year)	32 is ista	ar's Signatu	ure A	and I		2-17	/ [[

			State of Man				nd Mental H	ygiene	25711
			State Registrar	Cer	tificate of D	Death		Reg. No.	25711
	Physicia	in/	1. Decedent's Name (First, Middle, Last)				2. Date of D		3. Time of Death
	Medic	cal	Willard H. Pinkn 4a. Facility Name (if not institution, give street and number)	ey			July	31, 2010	7:18 A ^M
٠,	Examir	ier			4b. City, Town, or			4c. County of E	eath ce George's
- 1	Funeral		Fort Washington Hospital 5. Social Security Number 16. Sex 17. Age (Ir	yrs. last birthday)	If Under 1 Year	Washi			
	Director		579-58-9892 1 M 2 □ F	64 Yrs.	Months Days			2, Year 1946	Birthplace (State or Foreign Country) DC
	*		Usual Residence of Decedent				_ cury	2, 2,770	
	land sho	ţ	10a. State 10b. County 10	c. City, Town or Lo	cation				10d. Inside City Limits
	Mar) 28a- otifie	Director	Maryland Prince George's		Fort Wa	ashing	ton		1 🌁 Yes 2 □ No
	h the kaor ben		10e. Street and Number		10f. Zip Code			10g. Citizen of What	Country?
	within 72 hours after death with the Maryland glene tribna "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Funeral	7614 Blanford Drive		207	744		United	States
	riter iner		11. Marital Status 12. Was Decedent Ever Armed Forces?		Vas Decedent of His Yes, specify Cubar	spanic Origin n, Mexican, P	? (Specify Yes or No uerto Rican, etc.)	14. Race - A Black, W	merican Indian,
99	al", o	d by	1 ☐ Never Married 2 🛣 Married 1 🍱 Yes 2 ☐ No If Yes, Give 1 ☐ Widowed 4 ☐ Divorced 1 ☐ Yes or Dates	1	☐ Yes 2 🔀 No	Specify:			frican
ŏ	atura ical E	Completed	Year or Dates. 15. Decedent's Education	16a Decer	lent's Usual Occupa	ation		A	merican
75	an "n Medi	臣	(Specify only highest grade completed)	(Give I	kind of work done du O NOT use retired)	uring most of	working	16b. Kind of Busine	ss Industry
7	within giene er the		Elementary/Seconday (0-12) College (1-4 or 5+)			perato	r	Pri	vate
p	filed tal Hyged of other event,	Be	17. Father's Name (First, Middle, Last)			18. Mother's	Name (First, Middle	e, Maiden Surname)	
<u>ya</u>	ld be Ment arke	မ	Henry I. Pinkney				Matti	e H. Burro	ughs
Maryland 21215-0036	should be file and Mental I is marked o raumatic eve		19a. Informant's Name/Relationship (Type, Print)					er, City or Town, State,	
<u>~</u>	and 2 s Health tem 27		Violet R. Pinkney/ Wife	7614	Blanford	d Drive	e Ft. Was	hington, M	d. 20744
0	Je 1 a It of H If ite or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispos cemetery, crem	sition (Name of natory or other place	e) .	Date	20c. Location - City	or Town, State
altimore,	t. Page tment o rtant: If ijury or	1			n Nationa		igust 7,		l, Maryland
Ba	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertall Hygiene. Important: If time ZI is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee		Name and Address	•		Funeral Ho	-
			23a. Pair 1. Enter the disease, or complications that caused the					hington, D	
			shock, or heart failure. List only one cause on each line.	death. Do not ente	r the mode of dying	, such as can	diac or respiratory a	irrest,	Approximate Interval Between
[-	Physician/ ∉ Medical		disease or condition Corona		y Disease	9			Onset and Death
*	Examiner		Due to (or as a co	nsequence of):					
		Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a co	nsequence of:					-
	rted d unsit	Examiner	if any, leading to immediate Due to (or as a co cause. Enter Underlying Cause (Disease or iinjury	,					
	execu an and ial-tra	Ex	that initiated events c. Due to (or as a co	nsequence of):					
9	certilicate be executed nding physician and use as the burial-transit	edical	d	·-·					
687	ng ph	Med	IF FEMALE:			_			
×	in cer tendi	ian/	23b. Was decedent pregnant 23c. If yes, outcome of print the past 12 months? 1 Live Birth 2	Fetal death 3	Ectopic pregnancy	,		23d. Date of	delivery
Rox	the atter	Physician/M	1	e of death 5	Other (specify)		·-	Month	Day Year
Э. :	ine iaw requires that the death certificate has been signed by the attending page 2 should be detached for use as		Part II. Other significant conditions contributing to death but no	ot resulting in the ur	iderlying cause give	on in Part I	22a Did		to the cause of death?
יני מ	signe	d by	J	stroodining at the th	id strying dadoo givo	ATTITION TO			Probably 4 Unknown
ğ	redull hould	ete		4.4.					
Hecords,	sician: The law certificate has b irector, page 2 s	Completed					— 24a. Was		autopsy findings available o completion of cause of
r	n: In ficate or, pag		25. Was case referred to medical				1 \ Yes	2 X No 1 □	res 2 No
Vital	sicia s certi lirecto	To Be	examiner?	. M. == /0	Other		Check only one)		
0	ariny erthis		27. Manner of Death 28a. Date of Injury	2 ER/Outpatient 28b. Time of	28c. Injury a			idence 6 Other (Sp how injury occurred	ecify)
5	ath. r: Aft	icat	1 XNatural 5 Pending (Month, Day, Yea 2 Accident Investigation	ar) injury	work? M 1 □ Y	′es 2 □ No			
DIVISION	recto	Certificate	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - building, etc. (S _L	At home, farm, stre	et, factory, office			Street and Number or I	Rural Route Number,
	irs affi al Di		Sulfullig, etc. (Sc				City or 10	wn, State)	
200	Fune ted fi	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examiner)	nation and/or investi-	gation, in my opinion.	 death occurr 	red at the time date	and place, and due to th	e cause(s) and manner stated
4	our nospina or Austranting Inysician, within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,		only one) 3 Certifying Nurse Practioner: To the best 29b. Signature and title of certifler	of my knowledge, de	eath occurred at the t	time, date and	d place, and due to the	ne cause(s) and manner	as stated.
F	- \$ F ō					20740		August 2,	
٦	2	ŀ	30. Name and address of person tho completed cause of death	(Item 23a) (Type Pr	int)				
	-/-	- 1	Gerald H. Harris, MD 106 Irvi			h Towe	r, Suite	4200 WDC	20010
	Stat	_	31. Date filed (Month, Day, Year) 32. Registrar's S						
	Registra	r	AUG 0 4 2010 Senera . S.	grave.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^D2010 $J_{\mathbf{u}}^{\text{Month}}$ 27, William Ruffus Patrick, Jr. 5:33 Ам Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 641 Houston Avenue Montgomery Takoma Park Social Security Number 8. Date of Birth
Dec. 7, 1942 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral 9. Birthplace (State or Foreign 1 🕱 M 2 🗆 F Months Days Hours West Director 233-66-3976 67 Yrs Virginia Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be any any any. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Takoma Park 1 X Yes 2 No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral # 405 20912 641 Houston Ave. United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces:

1 X Yes 2 If Yes, Give
Year or Dates. Black, White, etc. Completed by 1 Never Married 2 Married 2 No Specify: Black 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 🖾 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William R. Patrick, Sr. Louise Ann Holliday 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherman Patrick/ Son 641 Houston Ave. # 405 Takoma Park, Md. 20912 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place).
Arlington National 20c. Location - City or Town, State Date 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State August 25, 4 Donation 5 Other (Specify) Arlington, Vriginia emetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, 4001 Benning Road NE Washington, DC 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final consequence of: Physician/ with disease or condition Medical resulting in death) Due to (or 💌 Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to for as a consequence of and I-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year certificate has been signed by the irector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed?
☐ Yes 2 No 1 ☐ Yes 2 ☐ No hours after death.

uneral Director: After this certific
of filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 KNo မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Sesidence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1. Natural 5 \square Pending iniury Accident Investigation Suicide
Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined

completed within 2

State Registrar

Geoffrey Coleman, MD 1355 Piccard Drive Rockville, MD 31. Date filed *(Month, Day, Year)* AUG 0 4 2010 32. Registraris Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical

29a. Certifier

(Check

29b. Signature and title of certifi

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

8-2-2010

20850

29c. License number

D37142

			1 - State Amended #2	State of per MD,	of Marylan RG FCH	d / Depa D 8/2/ Cer	artment of F 10 <i>tificate of L</i>	lealth and Death	Mental Hyg	iene leg. No 20	10	257	713
	Physicia	in/	1. Decedent's Name (First, Middle	, Last)					2. Date of Deat		2010	3. Time of 6:02	
	Medic Examin	cal	Richal 4a. Facility Name (If not institution)	rd Thurman		Jr	4b. City, Town, or	Location of Deat			y of Death	0:02	Рм
) ======		Frederick				F	rederick			reder	ick	
	Funeral Director		5. Social Security Number 444-40-8610	6. Sex. 1 ★ M 2 ☐ F	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		^{Year} 927	9. Birthp Count Tenne	lace (State o ry) SSEE	r Foreign
	and show at	'n	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Loc	cation				10	Od. Inside Ci	ty Limits
	Maryk 28a-f : otified	Director		erick	Thu	rmont						1 🗆 Yes	2 X No
	vith the 23a or st be n	ral D	10e. Street and Number 11709 Old Fre	derick Ro	ad		10f. Zip Code 21788	.		10g. Citizen of USA	What Count	try?	
36	2 should be filed within 72 hours after death with the Maryland th and Mental Hyglene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	d by Funeral	11. Marital Status 1 Never Married 2 Marriad 3 Widowed 4 Divorced	ried Armed Fo 1 ☑ Yes If Yes, Giv	2 🗌 No re	H	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		ce - America ck, White, e		
2-00	2 hours "natura	plete	15. Deceder	Year or Dant's Education st grade completed)		16a. Deced	ent's Usual Occupation of work done of	ation	rkina	16b. Kind of E	Business Ind	ustry	
121	ithin 73 iene. r than the Me	Completed	Elementary/Seconday (0-12)	5+ College (1		Manage	O NOT use retired)	uning most of wo	Airig	NIST			
Maryland 21215-0036	be filed w ental Hyg ked othe ic event,	To Be	17. Father's Name (First, Middle, L Richard Thurma:	•	r.	1			me (First, Middle, N armbrod	flaiden Surnam	ne)		
Mary	should I and Me rs mark raumatii		Richard Thurman Penn, Sr. Ruth Warmbrod 9a. Informant's Name/Relationship (Type, Print) Patricia Penn - wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 11709 Old Frederick Road, Thurmont, Ma										21702
	and Hea Item		20a. Method of Disposition	WIIC		Place of Dispos	sition (Name of			20c. Location			21702
altimore,	Page nent c ant: If		1 ☐ Burial 2 🔀 Cremation 4 ☐ Donation 5 ☐ Other (S				cremator Cremator			rederi			d
Bai	permit. Departr Importa any inju		21. Signature of Funeral Service	amille	Olen				auffer F Pike, Fre			aland	2170
		0	23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that only one cause on ea	caused the deat							Approximate Interval Bette Onset and I	ween
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequ		Zenal	failur	2				
	Examiner	er	Sequentially list conditions,	b. ———		nsep	515				_	3 days	
	nted d ansit	Examine	if any lasting to immediate cause. Enter Underlying Cause (Disease or linjury	Due to p	or as a conseut	ience of):							
	certificate be executed nding physician and use as the burial-transit	dical Ex	that initiated events resulting in death) Last	Due to (or as a consequ	uence of):							
68760	ificate k ig phys as the l	Medic	IF FEMALE:	d					-				
Box	death he atte ed for	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live I	nant at time of o	Ideath 3	Ectopic pregnanc Other (specify)	у			ate of deliver onth	*	/ear
ds, P.O	requires that the been signed by the should be detach	ed by Pl	Part II. Other significant condition	ns contributing to de	eath but not res	ulting in the ur	nderlying cause giv	en in Part I.		oacco use con			
	To the Hospital or Attending Physician: The law rev minin 24 hours after death. This centificate has been completed filled in by the funeral director, Assertations of the completed filled in by the funeral director, page 2 sho	Completed							24a. Was ar autops perforn 1 🗌 Yes 2	y ned?	Were autop prior to con death? 1 Yes	sy findings anpletion of ca	vailable suse of
/ital	s certifi	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🏞 No	Hospital:	Inpatient 2 🗖	FR/Outpatien	Otho	ce of Death (Che	ck only one)		er/Coopiful	ETAI ET	LG WEY
101	ing Phy I. After this uneral o		27. Manner of Death 1 → Natural 5 □ Pendin	28a. Date		28b. Time of injury	28c. Injury work	at	28d. Describe ho			<i>\$</i>	
ISIO	Attend er death ector: A by the f	Certificate:	2 Accident Investig 3 Suicide 6 Could i 4 Homicide determi	not be 28e. Place	of Injury - At ho	me, farm, stre	M 1 L	Yes 2 No	28f. Location (Str		er or Rural I	Route Numb	er,
2	pital or ours afte eral Dir filled in		29a, Certifier 1 Certifying	Physician: To the be			coursed at the time	date and place.	City or Town		or an atatoa		
	the Hos hin 24 h the Fun npleted	Medical	(Check 2 Medical E only one) 3 Certifying	xaminer: On the bas Nurse Practioner:	is of examination	n and/or investi	gation, in my opinio eath occurred at the	n, death occurred time, date and plant	at the time, date and	d place, and du	e to the caus	se(s) and mar	ner stated.
	Vit To COI		29b. Signature and title of certifier Muhan	1 / Nex	~ m	0	29c. License	number D4719		9d. Date si g ne أب	d (Month, D	ay, Year)	0
	etIVA		30. Name and address of person w	vho completed caus	e of death (Item	23a) (Type, Pr	rint)			10 2	1701		
Ì	Stat Registra	_	31. Date filed (Month, Day, Year)		egistrar's Signat	ure	barker		acce in				
				/			/						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year ale orraine 658PM 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Magerstown Washington County Hospita Jashing Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6 Sex 7. Age (In vrs. last birthday) g. Birthplace (State or Foreign Funeral 217-28-5712 Hours 1 🗆 M 2 💢 F $Nov^{(Month, Pay)}$. ^{Year}1931 Mary land 78 Director Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Maryland Washington County Hagerstown 1X Yes 2 □ No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 910 Concord St. 21740 U.S.A. and Mental Hygiene. is marked other than "natural", or items death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. 1 Never Married 2 Married Completed by 2 X No 72 hours after ☐ Yes Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give 3 X Widowed 4 ☐ Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16h Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Fage 1 and 2 should be filed with.
Department of Health and Mental Hverlimportant: If item 27 is markany injury or other? Homemaker Personal Residence Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maurice Leroy Dunkin, Sr. Viola Corine Diffendaffer Dunkin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna K. Sales-daughter 910 Concord St. Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Park 8-4-2010 Hagerstown, Maryland 21. Signature of Funeral Service Licer 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern BLvd. North Hagerstown, 23a. Part 1. Enter the disease, o shock, or heart failure. List or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stimly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Shock disease or condition Medical resulting in death) Due to (or as a c sequence of Examiner Preumonio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. attending physician and for use as the bunal-transit Exam that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No Month 5 Other (specify) Pregnant at time of death Day Year been signed by the should be detached 1 ☐ Yes ∠ µ 9 ☐ Unknown 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 💆 No 3 ☐ Probably 4 ☐ Unknown this certificate has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 performe yes 2 No 2 🗌 No 1 Tes Be (25. Was case referred to medical funeral director. 26. Place of Death (Check only one) 2 💢 No Other: 뎯 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred eral Director; After filled in by the funer 1 X Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours and To the Funeral E Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 006

State

DHMH 17 Rev 7/2009

Registrar

shington

HOS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TUM

31. Date filed (Month, Day, Year)

BeyEre

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month June Lorraine Powers 3:46 P M August 2010 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Reeder's Memorial Home Washington County Boonsboro 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 1 □ M 2 🛛 F Months Days Hours Min. 2**19-**20-1967 83 1926 Dec. Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Washington County Boonsboro 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 141 S. Main St. 21713 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Specify: Specify: White 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Waitress Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Roger Carl Randall Minnie May Knight Randall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vickie L. Sampson-daughter 398 Bryan Place Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Cedar Lawn Mem. Park 8-6-2010 Hagerstown, Maryland 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Lice 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) TO THRIVE MILURE MONTHS, Due to (or as a consequence of): CACCHETUA MUNTLES, Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last DEMINITA Morried yenne, Due to (or as a consequence of) HOSPICIE MONRH 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 1 🗆 Yes 1 ☐Yes 2 No 2 No 25. Was case referred to medical 26. Place of Death (Check only one

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

by Funeral

Completed

Be

Funeral

Director

ntal Hygiene. 3d other than "natural", or items 23a or 28a-f shov event, the Medical Exar, instrinet be notified at

is marked other

permit. Pages 1 and 2 should be Department of Health and Menta Important; If item 27 is marked any injury or other traumatic ev

with the Maryland show

Name: Powers, June Baltimore, Maryland 21215-0036

burialattending physician for use as the buris the þ signed be det has certificate director, funeral

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Examiner Physician/Medical þ Completed Be

Medical Certification: To

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No

1 Tes 2 No

27. Manner of Death

1 Natural

2 Accident

4 Homicide

3 Suicide

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certifier MO

5 Pending

investigation 6 ☐ Could not be determined

046561

20311 Lappans Rd, Boonsboro, Maryland 21713

Hugust 03 2010

301-790-0666

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Ghazala Qadir 31. Date filed (Month, Day, Year)

AUG 33

distrar's Signature

State

Registrar

n 24 hours after death.

In Funeral Director: A pletely filled in by the fu

To the within 2

completely

			For State Registrar		State	of Maryla		artment (<i>rtificate</i> (d Mental H	ygiene Reg. N	201	0	257	16
	Physicia Medi		1. Decedent's Name	e (First, Middle,	Last)	F	E .	PARSLEY	7		2. Date of I Month July	Death D	ay,	Year	3. Time of De 12:15	
	Examir		4a. Facility Name (if	not institution,	give street and nun	nber)	-	T		ocation of De			c. County o			
	Francis		Frederi 5. Social Security No.		rial Hos	pital 7. Age (In yrs.	last hirthday	Fred	deri	CK f Under 24 H	re o D-t4.5		Frede			
	Funeral Director		579-46-	2289	1 M 2 □ F	7. Age (iii y/s.	Yrs.			Hours M		7193	37 W	9. Birthp Count ASH	ace (State or Fory) DC	oreign
	and show at	ō	Usual Residence of 10a. State	10b. County		10c. C	ity, Town or Lo	cation						10	Od. Inside, City L	∟imits
	Maryla 28a-f	rect	MD	FRED	ERICK		FREDEF	RICK							1 🗹 Yes 2	
	with the 23a or 2	Funeral Director	10e. Street and Num		h STREE	T.		10f. Zip Co	701			10g. C	itizen of Wh	nat Count	ry?	
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	è	11. Marital Status 1 Never Marrie 3 Widowed 4	ed 2 Marrie	12. Was Dece	edent Ever in U rces? 2 \(\text{No1 9}\)	54- '	D-	14. Race -	America White, e	tc.					
21215-0036	in 72 hour e. nan "natu : Medical	Completed	(Spec				(Give	lent's Usual Ookind of work do O NOT use ret	one durii		rorking	16b. F	Kind of Busi	ness Ind	ustry	
2	d with fygien ther th nt, the	Be C	12				WATER	METE	R R	EADEF	<u> </u>	PAW	ER D	EPA	RTMENT	1
/lanc	d be file Mental H arked o	To B	17. Father's Name (F		^{st)} PRY PARS	LEY					lame (First, Middle ELIZA			INS	NC	
Baltimore, Maryland	2 shoul th and I 27 is ma trauma		19a. Informant's Nar			יטשבים					Rural Route Numb					
ore,	of Heal of Heal fitem		20a. Method of Dispo	osition		20b.	Place of Dispo	sition (Name o	f	OKIHI	DR.,	T	ocation - C			
<u>ti</u>	it. Page intment intant: I njury o		4 Donation	5 Other (Sp		State ST.	cemetery, cren	CREM	ATO		/28/20	10	FRED	ERI	CK, MD	,
Ba	perm Depa Impo any i		21. Signature of Fun	er Se yice Li	ensee			. Name and Ad ILTON			HOME	P O BÅRN	BOX ESVI	LLE LLE	, MD	
- 1	Physician/		Immediate Cause (F	italiure. List on inal	y one cause of	caused the dea th line.	144	r the mode of	dying, s	uch as cardi	ac or respiratory a	arrest,			Approximate Interval Betwee Onset and Deal	
	Medical Examiner		resulting in death)			or as a conseq	. ,								Dung	
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.													
0	icate be executed physician and s the burial-transit	ledical Ex														
09/89	tificate ng phy as the	Med	IF FEMALE:		— u							-				
. Box 6	requires that the death certific been signed by the attending I should be detached for use as	Physician/M	23b. Was decedent p in the past 12 m 1 Yes 2 U 9 Unknown	onths?		Birth 2 🗀 Fet nant at time of	al death 3 🗌	Ectopic pregi Other (specify					23d. Date of Month		y Day Year	
Is, P.O	uires that thas tha signed by	þ	Part II. Other signific	ant condition	s contributing to de	eath but not res	sulting in the ur	nderlying caus	e given i	in Part I.					cause of death	
×	2 8 €	Completed									perf	opsy ormed?	prio dea	or to com th?	y findings available pletion of cause	able e of
g	strifica ctor, p		25. Was case referred examiner?	to medical				26	6. Place	of Death (Ch	eck only one)	2 N	0	Yes 2	□ No	
=	Physic this co al dire	유	1 🗆 Yes 2 🔉	No			ER/Outpatient	: 3 □ DOA	Other:	I ☐ Nursing	Home 5 Res	idence 6	Other (Specify)		
o E	ding F th.: After funera	cate:	27. Manner of Death 1 Natural 2 Accident	5 Pending		of injury h, Day, Year)	28b. Time of injury	V	njury at vork?	2 🗆 No	28d. Describe	how injur	y occurred			
DIVISION OF VITAL	al or Atten s after dea I Director: d in by the	Certificate:	3 Suicide 4 Homicide	6 Could no determine	t be 28e. Place	of Injury - At ho g, etc. (Specify	ome, farm, stre			2 🗆 110	28f. Location (City or To	Street and	d Number o	r Rural R	oute Number,	
_	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate he completed filled in by the funeral director, page	Medical	(Check 2 L	J Medical Exa	hysician: To the be mineri On the basi urse Practioner: T	s of examinatio	n and/or investi	gation, in my or	pinion, de	eath occurred	at the time date	and place	and due to	the cause	e(s) and manner	stated.
	To t To t		29b. Signature and tit		7			29c. Lice	ense nur	nber		29d. Dat	te signed (N	1onth, Da	y, Year)	
		-	30. Name and addres	s of person wh	o completed cause	e of death (Item	1 23a) (Type, Pr		,7,00	- 61	Au,		- 26-	10		
	6HVA		31. Date filed (Month,	Ca	idi M	10	108	Toll	H	ouse	Au,	Fre	ederic	il.	140 917	70/
	Stat Registra	7	J. Date filed (IVIONIN,	IIII O	9 2010 N	gistrar's Signa	ture	he no the	1		,					

Amend 28A p							
10-05634 AACO	H	8-5-10 Please Type or Print in Black Indeli	ble Ink. Ensu	re All Copie	s Are Leg	jible.	
Christopher Micl	hae			nd Mental Hy	/giene	2010	25717
Physicia	an/	Registrar Certifica 1. Decedent's Name (First, Middle,Last)	ate of Death		2. Date of Deat	g. No.	2. Time of Death
Medical Exami		01 1 1 1 1 1 1 1 1			Month July 27, 20	Day Year	3. Time of Death 2345 hrs
;		4a. Facility Name (if not institution, give street and number)	4b. City, Town,	or Location of Death	July 27, 20	4c. County of Death	
		7400 Blk. Quail Ridge Lane	Bowie			Prince George	e's
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth		ear If Under 24Hrs. ays Hours Min.	8. Date of Birt	h(MM/DD/YYYY) 9. Bir Foreig	thplace (State or
Director		228-55-3900 1XM 2 F 20	Yrs.	ays Hours Will.	08/28/	1989 co	^{untry)} Virginia
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of	or Location				10d. Inside City Limits
≹	L		2004(10)				1 XXYes 2 No
arylan 8a-f s	Director	Maryland Prince George's Bowie 10e. Street and Number	10f. Zip Code		10	g. Citizen of What Cour	
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show a matic event, the Medical Examiner must be notified at once.	Ö	7415 Quail Ridge Lane	20	0720		U. S. A.	,
n with	uneral	11. Marital Status 1. Vas Decedent Ever in U.S. Armed Forces?	13. Was Decedent of H	Hispanic Origin? (Spe	ecify Yes or No-	14. Race - Ameri	can Indian, Black,
r deatl	Fun	1 Yes 2 No	ir res, specify Cuba	an, Mexican, Puerto I	Rican, etc.)	White, etc.	
rs afte rral", miner	ģ	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. D	1 Yes 2 X N			Specify: Wh	
2 hour	ted	Elementary/Secondary (0-12) College (1-4 or 5+)	ecedent's Usual Occup uring most of working lif	pation (Give kind of wi fe. DO NOT use retire	ork done ed)	16b. Kind of Business/li	ndustry
15-0036 filed within 72 hours after in Hygiene. ed other than "natural", o	Completed	12	Houseman			Hotel Indu	istry
5-0 Hygie		17. Father's Name (First, Middle, Last)		18.Mother's Name	(First, Middle, M		13 01 9
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Sooksud Chandadipar		Gabriell			eroni
Baltimore, MD 21218 permit. Pages I and 2 should be fil Department of Health and Mental H Important: If iten 27 is marked. injury or other traumarite event. I	၉					per, City or Town, State,	
e, M and 2 lealth tem 2 traun			415 Quail R Disposition (Name of co	emetery.		Maryland 20c. Location - City or	20720
nore ages 1 at of H		1 X Burial 2 Cremation 3 Removal from State cremator	ry or other place)	·		•	
Baltimore, pernit. Pages I an Pepartment of Hea Important: If ite njury or other tr.	1	4 Donation 5 Other Specify: 1 W 11 V 21. Signature of Funeral Service Licensee.	Tarrey Melli.	ss of Facility Dob	31/2010	Delmont, P	ennsylvania
Balt permit. Depart Import		Del- / Friends	16000 Anna	nolis Roa	eri E. d Rowi	Evans Funer e, Maryland	al Home,
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not failure. List only one cause on each line.	enter the mode of dying	g, such as cardiac or	respiratory arres	st, shock, or heart	Approximate Interval
/Medical Examiner		Immediate Cause (Final disease a. Asphyxia by hanging					Between Onset and Death
		or condition resulting in death) Due to (or as a consequence of):		_			
	ĕ	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):					
	amine	cause. Enter Underlying Cause (Ursaas) or Iriginy that Initiated events resulting in death). Last					
uted id ransit	ш	events resulting in death) Last Due to (or as a consequence of): d.					
, P.O. Box 68760, ires that the death certificate be execut signed by the attending physician and be detached for use as the burial - transition of the stack of the stack of the stack of the stack of the burial - transition of the stack of	sician/Medical	UNPENDED AMENDED		-	<u> </u>		
Box 68760, a death certificate bette attending physical of for use as the burned for use	Me	IF FEMALE: 23c, If yes, outcome of pregnancy				23d. Date of delivery	_
68 certifi nding ise as	ian	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 4 Pregnant at time of death s	Fetal death 3	Ectopic pregnan	су	Month Da	ay Year
Box death	ysic	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown	Other (Specify)				
O. I	Phy	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause	given in Part I.	23e. Did tob	acco use contribute to the	ne cause of death?
s, P.O.	g b				1 Yes	2 ✓ No 3 Proba	ably 4 Unknown
cords, law requir has been s	Completed				24a. Was an autopsy		opsy findings available impletion of cause of
Reco	Ē	-	-		perform 1 Yes 2	ed? death?	
Vital Rec hysician: The I this certificate I director, page	Be	25. Was case referred to medical examiner?	26.Place	e of Death (Check on	ily one)		
Division of Vital Records, tal or Attending Physician: The law requires after death. al Director: After this certificate has been side in by the funeral director, page 2 should be a sho	의	1 V Yes 2 No Rospital 1 Inpatient 2 ER/Outp	patient 3 DOA			esidence 6 🗸 Other:	Scene
n of oding Ph. h. : After t	ᇹ	27. Manner of Death 28a. Date of Injury 28b. Tin 1 Natural 5 Pending 1 Pending 28b. Tin			8d. Describe ho ubject hange	w injury occurred ed self	
ivisior for Attendather death Director:	icat	2 Accident Investigation 38e Place of thirty 4t home farm			Of Logotion (Ctr	est and N. who D.	10-4-1
Division or At ours after deral Direct filled in by	ertification:	3 ✓ Suicide 6 Could not be determined (Specify) Park/Recreation A			or Town, Sta	eet and Number or Rura te) Ridge Lane , Bowie, I	
Hospital 24 hours Funeral tely fillec	아	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the timeral director, page 2 should be detached for use as the burial - transi	Medical	one) 2 Medical Examiner: On the basis of examination and/or inve					
	ž	29b. Signature and title of certifier	29c. Licens			29d. Date signed (Mont	h, Day, Year)
		Call VI	O.C.	M.E.		July 28, 2010	
1112	ſ	30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111	Donn Stract D-11	timoro MD 0400)1		
Sta	Te l	31. Date filed (Month, Day Year) 32. Redistrar's Signature	Penn Street, Balt	umore, MD 2120	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
Registr		JUL 3 0 2010 Lives A.	back				

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AUGUST Day 2018 OLIVE SMITH PIERCE 9:20а м Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 56 Snug Harbor Way Earleville Cecil . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Days 1 🗆 M 2 🔽 F Months ^{ar)}191**2**Pennsylvania Director 183-10-6808 98 Usual Residence of Decedent 28a-f shor 10a. State 10b. County 10c. City, Town or Location event, the Medical Examiner must be notified at Director MD Cecil Earleville 1 Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 56 Snug Harbor Way 21919 U.S.A. 12. Was Decedent Ever in U.S. 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. "natural", or Completed by 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White 3

Widowed 4 □ Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) il Hygiene. I other than "i Elementary/Seconday (0-12) College (1-4 or 5+) Retail Sales Department Store and Mental Hygie is marked other Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Leon Childs Olive Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is Janet Pennington (daughter) Salem, SC. 36 Cardinal Point 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Dopation 5 Other (Specify) cemetery, crematory or other place) injury or Glenwood Memorial: 8/9/10 Broomall, PA. 22. Name and Address of Facility Galena Funeral Home of Stephen L Schaech M00510 West Cross St. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Myte disease or condition Due to (or as a consequence of) Medical resulting in death) Examiner Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and the burial-trar Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown Day Year signed by the at d be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform this certificate Yes 2 X No 1 L Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) 2 XNo 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at after death. Director: After 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be the Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital 624 hours a within 24 hours a Medical Decrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated itle of certifier ed (Month, Day, Year) Name and address of person who completed cause of death (Item 23*a*) (Type, Print) 10 33N ONSON 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Louise Kelly Pearson Medical August 2010 00 4a. Facilify Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 10909 Wolfsville Road <u>Mversville</u> Frederick Birthplace (State or Foreign Country) **Funeral** Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth 1 M 2 T Hours Min. (Month, Day, Year) 02/21/192 85 Director 243-36-6659 North Carolina 28a-f show 10a. State hours after death with the Maryland 10b. County 10c. City, Town or Location the Medical Examiner must be notified at Director 10d. Inside City Limits MD Frederick 1 ☐ Yes 2x ☐ No Myersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 10909 Wolfsville Road 21773 items 2 United States 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ò Black, White, etc. \$ 1 Never Married 2 Married 1 ☐ Yes 2 🌠 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: "natural", 3 ₩ Widowed 4 □ Divorced Completed Specify: white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important; If item 27 is marked othe any injury or other traumatic event; it Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Roland Kelly Clara Howard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Pearson, Jr./ son <u>10909 Wolfsville Rd., Myersville, MD 21773</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ★Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) nam Vets Cem ! 08/12/2010 | Cheltenham, MD 22. Name and Address of Facility Keeney & Basford Funeral Home Cheltenham Vets Cem Signature of Funeral Service Licenses ulu Kri an MO1222 106 E. Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) or as a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy for Day Pregnant at time of death 5 Other (specify) Month Year within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 🗋 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA 4 🗆 Nursing Home 5 Residence 6 Other (Specify) 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Investigation 2 🗌 No Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year)

Registrar

State

TJ Drive

Frederick.

MD 21702

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Convey

45

William H.

31. Date filed (Month, Day, Year)

AUG 1 7 2010

			For State		State of	Marylan					and M		2 0	1 0	25720		
			Registrar 1. Decedent's Name	(First Balada) - 1	ant)		Cer	tificate	of L	eath			neg. Nep	10	T -		
	Physicia	ın/		. ,	asi)	T. 4 T. 4 T.	****					Month		Year			
	Medic		4a. Facility Name (if r	NELSON	ve street and number	PALAD:	TNO	4h City	Taum av	Leastion	of Dooth	August	T .		TT:00 FM		
	Examin	ier			ial Hospi				eder		Dealli				k		
	Funeral		5. Social Security Nu	mber 6.	Sex 7.	Age (In yrs. la	ast birthday)	If Under	1 Year	If Under		8. Date of Birt	h	9. Birthr	place (State or Foreign		
	Director		N/A		1 XX M 2 □ F	52	Yrs.	Months	Days	Hours	Min.	$Jume^{th}$ 13	, Yea 1958	N9C2	Tagua		
	p A t	_	Usual Residence of I	Decedent 10b. County		10c City	y, Town or Loc	nation						Т.	Ind Incide City Limite		
	arylan a-fsh fied a	윊	MD	Washir	noton		gersto								-		
	or 28	Director	10e. Street and Num		18011	110,	BCIBCO	10f. Zip	Code	-		т	10a Citizen of V	What Cour			
	with th	eral	11561 Ro	binwood	Dr. Apt.	12			2174	1 2					my.		
	eath tems	Funeral	11. Marital Status		12. Was Decede	nt Ever in U.S		Vas Deced	ent of His	spanic Orig	gin? (Spe	cify Yes or No-			an Indian,		
9	fter d , or i		1 Never Marrie		Armed Force 1 Yes 2 If Yes, Give	X No			•								
8	ours a tural' al Ex	Completed by	3 Widowed 4		Year or Dates	3.					MICA	Laguan	Specify.	Mes	stizo		
15-	72 hc n "na fedic	ם	(Spec	15. Decedent's cify only highest of	Education grade completed)		16a. Deced		k done di		August 1. 2010 11:05 PM 4c. County of Death Frederick 24 Hrs. 8. Date of Birth Min. Jume 1953, Year 1958 9. Birthplace (State or Foreign Nicotrin, Pay Year 1958) 10d. Inside City Limits 1						
12	ithin iene.	ပ္ပ	Elementary/Seco	nday (0-12)	College (1-4	or 5+)	Cook		retirea)				Food S	Servi	ce		
þ	iled w I Hyg othe rent,	Be	17. Father's Name (F					•		18. Mothe	er's Name	(First, Middle, I	Maiden Surname	e)			
/lar	d be f Aenta arked stic ev	2	Jose Pa	ladino 1	Correz					Nei	ria I	ncer					
lan	ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Nar	me/Relationship	(Type, Print)		19b. Mailin	g Address	(Street a	nd Numbe	er or Rurai	Route Number	; City or Town, S	State, Zip C	Code)		
≥,	Ind 2		Clara B.		Wife					od Dr	c., E	lagersto			<u>:-</u>		
Ore	ge 1 a t of F If ite or ot		20a. Method of Dispo 1 Durial 2		Removal from St	. I o	lace of Disposemetery, crem	natory or of	her place	e)		I		-			
Baltimore, Maryland 21215-0036	it. Pag rtmer rtant njury		4 Donation			5ш.								0.			
Ba	permit. Page 1 and Department of Hambortant: If ite any injury or of any injury or of once.		21. Signature of Fund	eral Service Lice	nsee												
			23a. Part 1. Enter th	e disease, or cor	mplications hat cau	sed the death				_				/II, FII			
	Pnysician/	2 0	shock, or heart Immediate Cause (F	failure. List only inal	one cause on each	line.			J						Interval Between		
	Medical		disease or condition resulting in death)		a. Due to (or	as a consequ	uence of):	~ 0	pho	-101		19		\rightarrow			
	Examiner	L	Consulation let ear	- Indoore	my	1+in	,le	Ca	rd	JOS.	R	ne	A-				
	D #	ine	if any, leading to imr cause. Enter Underly	mediate ying	Due to (or	as a consequ	ience of):						(
13.	and trans	xan	Cause (Disease or iii that initiated events resulting in death) La		C. — Due to (or	as a consequ	ionno of:							\rightarrow			
	ate be executed ohysician and the burial-transit	dical Examiner	resulting in death) La	ast		as a consequ	ierice oi).										
760	cate by phys	edic			d												
687	attending p	n/N	IF FEMALE: 23b. Was decedent p	pregnant	23c. If yes, outcor	ne of pregnar							23d. Dat	te of delive	erv		
Вох	e atte	sicia	in the past 12 m 1 Yes 2		4 Pregnar			Ectopic p Other (spe		<i>y</i>			Mo	nth	Day Year		
Ö.	hat the de ed by the detached	Physician/Me	9 Unknown		9 🔲 Unknow							_					
, P.O.	v requires that been signed to should be deta	ρ	Part II. Other signific	cant conditions	contributing to deat	h but not resi	ulting in the ur	nderlying c	ause give	en in Part I			1				
rds	een si ould	sted										1 L Y	es 2/1 No	3 L Prob	oably 4 ∐ Unknown		
000	has b	Completed	-									autop	sy F	prior to cor	osy findings available mpletion of cause of		
Ä	sician: The la certificate har rector, page		25. Was case referred	d to modical								1 Yes			2 □ No		
/ita	siciar certif	m	examiner?	,	Hospital:	-4:4 0 🗆	ER/Outpatien	. a \Box no		r .			Obtentio		-V410		
of/	nding Physician: T th. : After this certifica : funeral director, p	e: To	27. Manner of Death		28a. Date of i	njury	28b. Time of	28	Bc. Injury work?						/		
no	ath. r: Aft	icat	1 Natural 2 Accident	5 Pending Investigation	on	Day, Year)	injury	М	work?	Yes 2	No						
Division of Vital Records,	I or Attendi after death Director: A I in by the fi	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determined	28e. Place of	Injury - At horetc. (Specify)		et, factory,	office		2			er or Rural	Route Number,		
Ö	pital c		00. 0. 17 1	9													
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2	Medical Exam	niner: On the basis of	f examination	and/or investi	gation, in n	ny opinior	n, death oc	curred at	the time, date an	d place, and due	e to the cau	use(s) and manner stated.		
	To the Within To the Somple	Σ	only one) 3 L 29b. Signature and tit)	ne best or my	Kilowiedge, d		License		ани ріасе						
			1 M	~ , I	Kee	Na		J M	00.3	351C	6		8/2	,	0/0		
	1		30. Name and address	ss of person who	completed cause o	f death (Item	23a) (Type, Pr	rint)				I.		′			
			myung	Hec N	*	00 u) THE S	S t	Fre	deri	ck,	MD 3	11701				
	Stat Registra	e	31. Date filed (Modth, AUG 172	Day, Year)	32. Regis	strar's Signati	ure										
	negistra	JI.	1100 A 7 6	JULY XX		2000	J										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death
Timenthy 28 pay 201 Orear 1. Decedent's Name (First, Middle, Last) Physician/ Celia Garcia Perez 5:48a Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death
Montgomery Silver Spring 12035 Veirs Mill Road #101 5. Social Security Number 6 Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛛 F Days none 45 Hours 3 / 9 13 9 1 9 8 5 Perty) Director Usual Residence of Decedent or 28a-f show notified at 10a State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Silver Spring MD Montgomery 1 Yes 2 XNo ō 10e. Street and Number 10f. Zip Code r than "natural", or items 23a or the Medical Examiner must be 10g. Citizen of What Country? Funeral 12035 Veirs Mill Road #101 20906 Peru death v 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Armed Force þ 1 Never Married 2 X Married Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 X Yes 2 □ No Specify: Peruvian White Completed 3 ☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h. Kind of Business Industry (Specify only highest grade completed) e filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home other traumatic event, Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname 9 Santiago Garcia Garcia Rosalvina Flores Benavides 19a. Informant's Name/Relationship (Type, Prinhusband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 Mariano Luis Perez Diaza 12035 Veirs Mill Road #101 Silver Spring, Md 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place Chesapeake Crem. 8/02/2010 Beltsville, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature PHILIP OF RENALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death UNG Ph sician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): the burial-transit and that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be exec resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Year Day g Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? eral Director: After this certificate has filled in by the funeral director, page 2 s performed Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 X No Other: 1 Tes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D64983 July 30,2010

Registrar
DHMH 17 Rev 7/2009

State

2101

Medical Park Dr. #200 Silver Spring, Md

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

Firozvi

Kashif

JUL

30

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25722 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 20 Year 756 Allan Pultz Charles Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HICANICO 344156444 YENINSUCA ROGIONAL 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday, **Funeral** 1**X** M 2 □ F Months Days Hours Min 6/1/1975 Country) Virginia 224-15-7254 Director 35 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits with the Maryland 10c. City. Town or Location Director Examiner must be notified 1X Yes 2 No Pocomoke City MD Worcester 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ò Funeral 23a USA 505 Walnut Street 21851 Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? ō þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates white 'natural", 3 Widowed 4 Divorced Completed er than "natur , the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) co-owner moving company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked မ Chris D. Baugher Charles J. Pultz 19a. Informant's Name/Relationship (Type, Pnint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 505 Walnut St., Farrah Pultz (wife) Pocomoke City MD 21851 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) permit. Page 1
Department of
Important: If i
any injury or c 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Salisbury Crematory 8/3/2010 Salisbury, Maryland 22. Name and Address of Facility Holloway Funeral Home, 107 Vine St., Pocomoke Signature of Funeral Service Licensee Professional Association City, MD 21851 Kat-1 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ due to hanging cusphypota disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) g physician and as the burial-transit Examir Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending phase as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav 5 Other (specify) Pregnant at time of death cate has been signed by the page 2 should be detached P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director. After this certifics completed filled in by the funeral director. It 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 □ No 1 Npatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 🗌 Yes 28d. Describe how injury occurred injury 1 Natural 2 Accident 5 Pending Selfinflicked hunginu 2 🗶 No 7126/10 DICC Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Garage @ home 505 walnut st Poconote Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Cartifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and 29d. Date signed (Month, Day, Year) 29c. License number 7/27/10 45049) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) arroll St. BAG 32. Registrar's Signature State

Registrar

0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Paredes Medical a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death nty of Death **Examiner** Doustal atthe 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🛛 M 2 🗆 F Months Days Hours (Month, Day, Year) Peru Director 20-51-3877 88 Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Completed by Funeral Director Examiner must be notified 28a-f 1 ¥ Yes 2 □ No Salisbury MD Wicomico 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 305 E. College Avenue 21804 Peru items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14 Race - American Indian Armed Force Black, White, etc. 5 1 Never Married 2 X Married 1 ☐ Yes 2 🛣 No If Yes, Give Maryland 21215-0036 1 X Yes 2 □ No Specify: Peruvian Specify: Peruvian 3 Widowed 4 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) perint. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Salisbury University Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Paredes Rosario Albarran Marcos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 108 N. Paula Lynne Drive, Seaford, DE 19973 John Paredes - Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 🗓 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 8-1-2010 Delmar, Delaware rematory of Delmarva: Signature of Fune al Service Lic 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. P 1. Enter the disease, or concer, or heart failure. List only tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ TATR disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami burial-tran and that initiated events Due to (or as a consequence of): resulting in death) Last signed by the attending physician d be detached for use as the burial Physician/Medical certificate be Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atter completed filled in by the funeral director, page 2 should be detached for u in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 □ Probably 4 □ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes → □ No 24a. Was an autopsy To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\triangle \text{Nursing Home} \) 5 \(\triangle \text{ Residence} \) 6 \(\triangle \text{Other} \(\text{(Specify)} \) HOSPICAL 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 \square Pending work?
1 Yes 2 No Natural کیات Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21802

DHMH 17 Rev 7/2009

State

Registrar

Huston

31. Date filed (Month, Day, Year)

WANY

SOX

32/ Registrar's Signature

MD

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Reeder Frederick Eugene 1:10 A M August 4 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Boonsboro 7822 Mountain Laurel Road Washington If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan 7. 1944 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 6. Sex 1 X M 2 ☐ F **Funeral** Months Days Hours Min Mary Land 215-42-2944 Director 66 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at Maryland Washington Boonsboro 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? , or Items 23a or 21713 7822 Mountain Laurel Road U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ZVes 2 □ No 196 If Yes, Give Year or Dates: 196 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1965-1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify þ 1967 Specify: 3 Widowed 4 Divorced permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", any injury or other traumatic event, Its Medical Example. White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) $\overset{\text{Elementary/Secondary (0-12)}}{12}$ College (1-4or 5+) Machinist Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Catherine McCarty ပ Harry Luther Reeder 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret V. Reeder/Wife 7822 Mountain Laurel Road Boonsboro, MD 21713 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Boonsboro Cemetery 08-06-2010 Boonsboro, Maryland 21. Signature of Funeral 22. Name and Address of Facility Bast-Stauffer Funeral Home. 7606 Old National Pike Boonsboro. MD 21713 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one fions that caused it. death. Do not enter the mode of dying, such as cardiac or respiratory arrest cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 0 year /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐No certificate has been signed by the irector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 🗆 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 24 hours after death.
Funeral Director: After this certifica etely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier To the within 2 and marner stated. ature and title of certifier 29b. Sign 29c. License number 29d. Date signed (Month, Day, Year) 30 Nas and address of person who completed cause of death (Item 23a) (Type, Print) 27H-6+1 25 MSS 1+1 111 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar 25725 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2<u>010</u> Physician/ July 21:22 М Vincent A. Randlett, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Health South Chesapeake Rehab Salisbury Wicomico Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days 1 🕱 M 2 □ F Hours 01/21/1938 Yrs 217-34-8361 72 Director MD Usual Residence of Deceden 28a-f shov 10a, State 10b County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director must be notified MD Carroll Westminster 1 Yes 2 No 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 4043 Salem Bottom Road 21157 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc 5 Completed by 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: White "natural" 3 Widowed 4 Divorced Specify. Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 10 Warehouse Worker Paper other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental F ၉ Page 1 and 2 should be Vincent A. Randlett, Sr. Freda Heleine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Vincent A. Randlett III - son 100 Taunton Avenue Catonsville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of Important: If it any injury or o once. of ☐ Burial 2 X Cremation 3 ☐ Removal from State 08/03/2010 4 ☐ Donation 5 ☐ Other (Specify) Ardent Crematory Hanover, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. MQ1044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Cardio Pulmonary Arrest Medical Due to (or as a consequence of) **Examiner** CHF Sequentially list conditions Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Sepsis that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Year 2 No 9 Unknown 9 Unknown s been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CAD S/P CABG \times 3 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of COPD, PVD 24a. Was an has autopsy death? certificate l Chronic Kidney disease 2 **X** No 1 ☐ Yes 2 XNo Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: |₽ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred 🛚 Natural 5 Pending injury 1 Yes 2 No after death Director: / ☐ Accident ☐ Suicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) within 24 hours a To the Funeral C Medical Excertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) D0064352 08/01/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nasiman Jaffery, MD 100 E Carroll Street Salisbury, MD

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Ad Ga 0 3 201

istrar's Signature

	1	For State Registrar	State	e of Ma	aryland			nt of F te of E		and N	/lental Hy	gien Reg. N	7 11	0	25726	
Physician.	_	1. Decedent's Name (First, Middle	, ,	, Dobi	ncon						2. Date of De	ath D	^{0ay} 3. 20	Year	3. Time of Death	
Medica Examine	_	4a. Facility Name (if not institution,	m Frank give street and		nson		4b. Cit	y, Town, or	Location	of Death	Augus		c. County of) 10 of Death	8:10 a ^M	
-		Calvert Manor					If I local		ing S					Ceci		
Funeral Director		5. Social Security Number 220–18–9559	6. Sex 1 M 2 M		(In yrs. Ia:	st birthday) Yrs.	Months	er 1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da OCt. 3	th i <i>y, Year</i>	27	g. Birthp Count Mar	lace (State or Foreign ry) yland	
and show d at		Usual Residence of Decedent 10a. State 10b. County			10c. City	, Town or Loc	cation							1	0d. Inside City Limits	
e Mary r 28a-f notifie		Maryland Ce	ecil					ing S	un			10- 0	Citizen of W	To a th C = 1 m	1 Yes 2 No	
with th	runeral	208 Dodson Dr	ive				101. 2	ip code	219	116		10g. C		.S.A.	•	
fter d	2	11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divorced	ried Armed	Decedent Event Event Event Porces? Ves 2 Notes Porces Por		II	Yes, sp	ecify Cuba	spanic Ori n, Mexicar Specify:	i, Puerto	ecify Yes or No- Rican, etc.)		14. Race Black Specify:	, White, e		
within 72 hou giene. er than "natu , the Medica	Completed	15. Deceder (Specify only highe Elementary/Seconday (0-12) Ten Years		ted) le (1-4 or 5+	+)	16a. Deced (Give I life. Do	kind of w O NOT u	ork done d se retired)	^{ation} <i>Juring mosi</i> perat		ing		rank's Ceramic Tile kford, Pennsylvania			
be filed be filed white better the country of control of the country of country of the country o	9 P	17. Father's Name <i>(First, Middle, L</i> Willian	_{ast)} 1 Slayte	er Rob	inso	n			18. Moth	er's Nam	e (First, Middle, Lulu					
should and Me is mar	ŀ	19a. Informant's Name/Relationsh	nip (Type, Print)			19b. Mailin	-				al Route Numbe	er, City o	or Town, Sta			
f Health f Health item 27 other to	-	Gary A. Robinso		(son)	20b. Pl	ace of Dispo:	sition (Na	ame of	- :		Provid		ce, PA		17560 wn, State	
t. Page tment o tant: If ijury or		1 Deurial 2 Cremation 4 Donation 5 Other (S	pecify)	rom State	R.Ã	.Ferri					04/10		Pen	nsyl	vania	
permit Depar Impor any in		21. Signal re of Funeral Service L	icensive	Man.	60	L²€	e e e e e e e e e e e e	end padres Perr	tersb yvill	h & e, M	Son Fur laryland	nera 1 2	1 Hom 1903-	ne, P 0766	P.A.	
		23a. Part 1. Enter the disease, or shock, or heart failure. List o Immediate Cause (Final	complications the only one cause of	nat caused n each line.	the death	. Do not ente	r the mo	de of dying	g, such as	cardiac o	or respiratory ar	rest,			Approximate Interval Between Onset and Death	
Physician Medical Examiner	Ì	disease or condition resulting in death)	a. Due	to (or as a	conseque	ence of):	CF	1-						+		
	<u>.</u>	Sequentially list conditions, if any, leading to immediate	b. Due	to (or as a	conseque	ence of):	U-	T1						-		
xecuted a and al-transit	Yall	cause. Enter Underlying Cause (Disease or impury that initiated events resulting in death) Last	c	to (or as a	concodu	anno of:										
cate be executed physician and the burial-transit	<u> </u>	resulting in death) Last	d	to (or as a	conseque	ence oij.										
Attending Physician: The law requires that the death certificate be executed at death. **T death.** **T death.* **T death.**	cially inject	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 □ ι	outcome o live Birth 2	2 🗌 Fetal	death 3	Ectopic		y				23d. Date		ery Day Year	
the destached	is l	1 🗌 Yes 2 🗎 No 9 🗍 Unknown	g 🗌 l	Jnknown												
requires that the death certific been signed by the attending is should be detached for use as	ה מ	Part II. Other significant condition	1	to death bu	t not resu	Ilting in the u	nderlyinç	g cause giv	ren in Part	l,			use contrib	_	e cause of death?	
The law requires ate has been signate page 2 should be		HT Ca	PD									psy ormed?	pr de		sy findings available inpletion of cause of	
ician: The certificate ector, pag		25. Was case referred to medical examiner?	Hospital:						ace of Deat	th <i>(Check</i>	1 L Yes	-2/A!	No. 1	L les	2 110	
g Physia er this c		1 ☐ Yes 2 No 27. Manner of Death	28a. D	Inpatientate of injury Month, Day,	/ 1	ER/Outpatien 28b. Time of injury		28c. Injury	4 Nu at		me 5 Resi					
or Attending P after death. Director: After t in by the funers	E	1. Natural 5 Pendin 2 Accident Investic 3 Suicide 6 Could	gation not be			ne, farm, stre	M est facto		Yes 2 🗆		28f. Location (Stroot o	nd Number	or Bural	Pouto Number	
ital or A Ins after al Direction by		4 L Homicide determ	bı	uilding, etc.	(Specify)						City or Tov	vn, Stat	re)			
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,		29a. Certifier (Check 2 Medical E only one) 3 Certifying	Physician: To the xaminer: On the Nurse Praction	basis of exa	amination	and/or invest	igation, i	n my opinio	n, death oc	ccurred at	the time, date a	and plac	e, and due	to the cau	se(s) and manner stated	
To the within To the complex c		29b. Signature and title of certifier	BIRIN		MD			oc. License		190	2		ate signed	1	-	
IVA	-	30. Name and address of person v	who completed of	cause of dea	ath (Item :	23a) (Type, P	rint)	100	002				0	2/2	21921	
State		SHAHNAWAZ 31. Date filed (Month, Day, Year)	KITAN	MD 2. Registrar	's Signati	W.H	1611	ST, J	SUIT	E3	14 , E	LK	TON,	MO	21921	
Registrar		AUG 0 4 2010	Cenn	+ /	1. 1	park										

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2810 Horace Paul Ramey 12855PM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Prince George's **Examiner** 4b. City, Town, or Location of Death Doctor's Hospital Lanham 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Mar** 24 9. Birthplace (State or Foreign **Funeral** Year) 9<u>21</u> Days Country) Finland 1 🖳 M 2 🗆 F Months Hours Min. 89 Director 212-38-6792 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f should may injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10d. Inside City Limits Director Prince George's Lanham 1 Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral United States 7010 Kingfisher Lane 20706 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 1030 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Completed by 1 Never Married 2 X Married Specify: White 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced 1939-68 Year or Dates. 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Navy Musician Be 17. Father's Name (First, Middle, Last) Maryland 18. Mother's Name (First, Middle, Maiden Surname) Daisy Webster Horace Blinn Ramey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AM 3523 Piney Woods Pl. #103, Laurel, MD 20724 Melissa Ramey / Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 CyCremation 3 Demoval from State 4 Donation 5 Other (Specify) Metro Crematory 07/28/2010 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause see each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 4 Pregnant 9 Unknown Month Pregnant at time of death 1 Yes 2 9 Unknown 2 🗌 No the been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1
Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an hasl autopsy performed' death? within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medica B B 26. Place of Death (Check only one) examiner? 2 TNO Certificate: To Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending ☐ Accident 1 Yes 2 No Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifie 🕒 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of certifie 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) Good huck Rd., Lanham 8118 State Registrar

DHMH 17 Rev 1/2001 OCME 2006

State Registrar parke

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

Melissa Brassell, MD

31. Date filed (Month Day)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2<u>010</u> Month Physician/ Mary Howard Rothrock Ju₁v 28 30 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Calvert Memorial Hospital Prince Frederick Calvert 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 1 □ M 2 🗶 F 11/09/1914 216-40-9988 95 Indiana Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 늄 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director Examiner must be notified MD St. Leonard Calvert 1 🗌 Yes 2 💢 No 5 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 7300 Stone Court 20685 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 27 is marked other than "natural", or i traumatic event, the Medical Examin þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 thand Mental Hygiene. 7 is marked other than "n Elementary/Seconday (0-12) Housewife Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Shirley Schumacher Wyoma Barnet permit. Page 1 and 2 should be Department of Heatth and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Rolston (Daughter) 7300 Stone Court, St. Leonard, Maryland 20685 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Sunset Hill Cemetery unk Rockport, Indiana Rausch Funeral Home, P.A. Signature of Funeral Service Licens 22. Name and Address of Facility O. Box 600, Lusby, Maryland 20657 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) neumonia Medical **Examiner** Sequentially list conditions Examine if any, teading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No signed by the atte Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 2 No 1 Yeş 4 Nursing Home 5 Residence 6 Other (Specify) 욘 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending work? 1 ☐ Yes 2 ☐ No after death. Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, completed filled in by determined within 24 hours a

To the Funeral D Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nuyse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the only one) and title of certifier 29b. Signature/ 29c. License number

DHMH 17 Rev 7/2009

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra s Signature

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August Dorothy Agnes Sheridan 2010 8:40p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 13422 Bartlett Street Rockville Montgomery 5. Social Security Number If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) If Under 1 Year 8. Date of Birth **Funeral** Country) Washington. 1 🗆 M 2 🕱 F Days June Months Hours 09 Yrs Director 86 579-24-4701 Usual Residence of Decedent 28a-f shov 10b. County 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Funeral Director Rockville 1 Yes 2 X No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20853 U.S.A. 13422 Bartlett Street 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married Yes 2 X No Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: Caucasian 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 's any injury or other traumatic event, the Me any injury or other traumatic event, the Me once. Washington, DC life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Government 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Marie M. Waters Frank Greatorex 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Margaret Dohme/Daughter 412 Chenoweth Drive. Stevensville. Maryland 21666 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 08/06/2010 | Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) Gate Heaven Cem. 06 re of Functial Service Lice 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part L Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 6 Months Immediate Cause (Final Physician/ Recurrent Colon Cancer disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 2 X No 1 ☐ Yes 2 D 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 2 X No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 😿 No 은 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 🗌 Yes 2 🗌 No 1 X Natural iniury 5 Pending 2 Accident
3 Suicide Investigation To the Funeral Director: completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a

To the Funeral E Medical 29a. Certifier 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 10 D22775 August 2, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #1300. Chevy Chase. Maryland 20815 Frederick Barr. 5454 Wisconsin Avenue. 31. Date filed (Month-Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Reg. No

2. Date of Death

Tor Amend Item 26 State of Maryland / Department of Health and Mental Hygiene State Registrar WCHD/SH 8/3/10 per Dr Certificate of Death

1. Decedent's Name (First, Middle, Last)

DHMH 17 Rev 1/2001

			State of Maryland / Dep	artment of Health and M	lental Hygie	ne 2010 25732
			Registrar 1. Decedent's Name (First, Middle, Last)	runcate or Death	Reg. 2. Date of Death	3. Time of Death
	Physicia Medic		BETTY BELL SURBER		JULY 2	7 2010 7:45 A M
	Examin	er	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
	Funeral		7198 ADIRONDACK DRIVE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	FREDERICK If Under 1 Year If Under 24 Hrs.	8. Date of Birth	FREDERICK 9. Birthplace (State or Foreign
H	Director		217-32-3107	Months Days Hours Min.	09/18/1	935 Country MD
	land show dat	tor	10a. State 10b. County 10c. City, Town or Lo			10d. Inside City Limits
	e Mary r 28a-f notifie	Director	MD FREDERICK FREDE			1 ☐ Yes 2 ☑ No
	within 72 hours after death with the Maryland gient then "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at the Medical Examiner must be notified at	eral [10e. Street and Number 7198 ADIRONDACK DRIVE	10f. Zip Code 21702	10g.	Citizen of What Country? USA
	items items	Funeral	11. Marital Status 12. Was Decedent Eyer in U.S. Armed Forces? / 13.	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto I	cify Yes or No-	14. Race - American Indian,
39	after al", or Examin	d by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No	1 ☐ Yes 2 ☑ No Specify:	iloan, otol,	Black, White, etc. Specify: WHITE
2	hours "natur dical I	plete	15. Decedent's Education 16a. Dece	dent's Usual Occupation kind of work done during most of working	168	b. Kind of Business Industry
12	ithin 72 ene. • than • the Me	Completed	Flementary/Seconday (0-12) College (1-4 or 5+) life. D	NOT use retired) K AND WAITRESS	'y	RETAIL
1d 2	filed w al Hygi s other vent, t	æ	17. Father's Name (First, Middle, Last)		(First, Middle, Maid	len Surname)
<u>S</u> a	should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	욘	TOWNSEND PAGE	MINNIE		
, Ma	1 and 2 should be of Health and Men item 27 is marke other traumatic		CONNIE WHISMAN/DAUGHTER 7198	ng Address (Street and Number or Rural ADIRONDACK DR.	, FREDE	r or Town, State, Zip Code) RICK, MD 21702
Baltimore, Maryland 21215-0036			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition cemetery, cre BOYDS C	matany or other place)	0/2010	BOYDS, MD
Balt	permit. Page Department Important: I any injury or once.		21. Signature of Funeral Service Licensee	2. Name and Address of Facility HILTON FUNERAL	HOME BAI	O. BOX 86 RNESVILLE, MD
			23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.		r respiratory arrest,	Approximate Interval Between
f	nysician Medical		Immediate Cause (Final disease or condition resulting in death)	un's Disease		Onset and Death
À	Examiner		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Sequentially list conditions, b.			
_	sit si	Examiner	if any, leading to immediate Due to (or as a consequence of):			
·	be executed sician and burial-transit	Exal	Cause (Disease or iinjury that initiated events resulting in death) Last C. Due to (or as a consequence of):	***		
Ŏ.	ite be e hysicia he buri	dical	d			
20 :	certifica inding ph use as ti	/We	IF FEMALE: 23b. Was decedent organism. 23c. If yes, outcome of pregnancy			
Box 687	death c he atten led for u	Physician/Med	in the past 12 months? 1 Live Birth 2 Fetal death 3 1 Ves 2 No 4 Pregnant at time of death 5	Cther (specify)		23d. Date of delivery Month Day Year
0.	at the c d by th etache	Phy	9 ☐ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the t	underlying cause given in Part I	22a Did tahasa	to use contribute to the cause of death?
лs, г	sician: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit	ed by		and any ing states given in that it		2 No 3 Probably 4 M Unknown
Vital Records,	law req las bee	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
P F	n: The ficate } ir, page		25. Was case referred to medical		performed	
VIta V	ysiciai is certi directo	To Be	examiner? 1 Yes 2 No	26. Place of Death (Check	. /	6 Other (Specify)
0 1	ing Ph		27. Manner of Death 1 Natural 5 Pending 28a. Date of injury 28b. Time of injury 28b. Time of injury	28c. Injury at work?	8d. Describe how in	
SIOL	Attendi death ctor: A ctor: A	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	Rf Location Street	and Number or Rural Route Number,
DIVISION	tal or / rs after al Dire ed in b		4 Homicide determined determined building, etc. (Specify)	22, 140.00), 0.1100	City or Town, Sta	
	Io the hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	l edical	29a. Certifier (Check only one) Check only one) Certifying Physician: To the best of my knowledge, death only one of the complete of the certifying Nurse Practioner: To the best of my knowledge, death only one only one of the certifying Nurse Practioner: To the best of my knowledge, death only one only one of the certifying Nurse Practioner: To the best of my knowledge, death only one of the certifying Nurse Practioner: To the best of my knowledge, death only one of the certifying Physician: To the best of my knowledge, death only one of the certification of the certi	tigation, in my opinion, death occurred at t	the time, date and pla	ace, and due to the cause(s) and manner stated.
ř	vithin To the	Σ	29b. Signature and title of certifier	29c. License number	29d. l	Date signed (Month, Day, Year)
			Ilm & Tuesso	003716	7-	-28-2010
	le		 Name and address of person who completed cause of death (Item 23a) (Type, Frekko Primary Care 19211 Montgome 	ry Village Ave. Su	iteB10L M	ont.Village,MD 20886
	Stat Registra	~	31. Date filed (Month, Day, Year) 28 2010 32. Registrar's Signature			
			AAC AA CARA SAARA SAARA			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death $\overset{\text{Month}}{Ju\,I\,y}$ Physician Edward P. Stevens, Sr. 2010 11:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner North Arundel Health & Rehab. Center Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye 11/13/31 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Year) Hours Days 1 ☑ M 2 □ F 78 MD Director 212-28-4533 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Caroline Preston 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3239 Gallagher Road 21655 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🛣 No White δ Specify: 3 □ Widowed 4 □ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Box Company permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumatic event, Inci. once. Shift Supervisor 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Georgette Madeleine Ashburn Robert Lee Stevens 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Donald W. Stevens/ Son 425 Pine Way Drive, Glen Burnie, MD 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park 08/03/10 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, P.A. 21. Signature of Funeral Service Licensee 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MACH archemi resulting in death) Due to (or as a consequence /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the as attending IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) the be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 McUnknown After this certificate has been si funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ▼No 24a. Was an autopsy 1 ☐ Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deatl

To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address afterson who completed cause of death (Item 23a) (Type, Print) Clean 31. Date filed (Month, Day, Year) 72. Registrar's Signature State AUG U2 Registrar

KN

		For State Registrar	State of Mary	land / D (epartment of F Ce <i>rtificate of L</i>	lealth and N Death	Mental Hygid Red	ene 2010	25734
Physici	an/	1. Decedent's Name (First, Middle, Las	•				2. Date of Death Month	Day Year	3. Time of Death
Medi Exami	cal	Sheldon Sn. 4a. Facility Name (if not institution, give	street and number)		4b. City, Town, or	Location of Death	<u> </u>	4c. County of Dea	
		University of Mary	land Medica		er Baltim	ore, MF	>		
Funeral Director		5. Social Security Number 6. S. 212–46–4425 1 Usual Residence of Decedent	7. Age (In) M M 2 \square F 66	yrs. last birtho	day) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Young) May 15, 1	9. Bi 944 Sou	rthplace (State or Foreign ountry) th Carolina
and show	tor	10a. State 10b. County		c. City, Town					10d. Inside City Limits
e Mary r 28a-f notifie	Director	MD Anne Ar	undel	Mill ——	ersville				1 ☐ Yes 2 🔀 No
s 23a or ust be r	Funeral [10e. Street and Number 312 Songwood Cot	ırt		10f. Zip Code 211	08	10	g. Citizen of What C USA	ountry?
I e, IN all ylail a ZIZIS-0030 I and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 Never Married 2 XMarried 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates.	1964– 1972	13. Was Decedent of Hi If Yes, specify Cuba 1 Yes 2 No	spanic Origin? (Spon, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:	
hin 72 hou ne. than "natu	Completed	15. Decedent's E. (Specify only highest gra Elementary/Seconday (0-12)		(G	Decedent's Usual Occupa Give kind of work done of fe. DO NOT use retired)	luring most of work	ing 16	6b. Kind of Business	
led wit Hygie other	Be	17. Father's Name (First, Middle, Last)	2		Lithographe 	•	ne (First, Middle, Ma	Printing iden Surname)	<u> </u>
ylall ld be fi Mental arked atic ev	욘	Alfred Snyder				Virgini	a Baker		
e, Mal ylalia ZIZIS and 2 should be filed within 72 Health and Mental Hygiene. tem 27 is marked other than "lither traumatic event, the Med		19a. Informant's Name/Relationship (T) Joyce Snyder / W:			Mailing Address (Street a				' '
Page nent o		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	Removal from State	Db. Place of E cemetery, Highvi	Disposition (Name of crematory or other place Memorial Gardens	e) Aug	net NA l	Cc. Location - City of Fallston,	
permit. Departr Imports any inju		21. Signature of Fund Service Licens	ee			SONS, P	.A. Sever	na Park F na Park,	uneral Home MD 21146
Pnysician		23a. Part (). Enter the disease, or comp shock, or neart failure. List only o Immediate Cause (Final disease or condition	ne cause on each line.					,	Approximate Interval Between Onset and Death
Medical Examiner		resulting in death)			inal her			7,1	
ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	Due to (or as a con		Pancreat	ne can	Cer		
cate be executed physician and the burial-transit		that initiated events resulting in death) Last	C. Due to (or as a con	sequence of)	:				
ficate by physical ph	Medical		d						
Attending Physician: The law requires that the death certificate be executed at death. **T death.** **ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pre 1 Live Birth 2 4 4 Pregnant at time 9 Unknown	Fetal death	3 Ectopic pregnanc 5 Other (specify)	y		23d. Date of de Month	olivery Day Year
quires that the series of series by suld be detailed.	þ	Part II. Other significant conditions co	ontributing to death but no	t resulting in	the underlying cause giv	en in Part I.			o the cause of death? Probably 4 \(\square\) Unknown
sician: The law re certificate has be irector, page 2 shr	Completed						24a. Was an autopsy performe 1 Yes 2	prior to death?	itopsy findings available completion of cause of s 2 No
sician sicertifi	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	2 T EB/Outo	26. Pla	r:		ce 6 Other (Spec	
To the Hospital or Attending Physician: within 24 hours after dead or After this certific completed filled in by the funeral director.		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day, Yea	28b. Tin	ne of 28c. Injury	at	28d. Describe how		Siry)
al or Atters after degrad in Director	Certificate:	3 Suicide 6 Could not be 4 Homicide determined		At home, farm ec <i>ify)</i>	n, street, factory, office		28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
ne Hospitt n 24 hours ne Funera pleted fille	Medical	(Check 2 L Medical Exami	sician: To the best of my kiner: On the basis of examine Practioner: To the best	nation and/or i	nvestigation, in my opinio	n, death occurred a	t the time, date and p	place, and due to the	cause(s) and manner stated.
To the Com		29b. Signature and title of certifier			29c. License		america)	I. Date signed (Mont	
		30. Name and address of person who c	ompleted cause of death (Item 23a) (Tiv		1955	3	vly 30	12010
		Leeor Joffe				- Balt	inore,	MD 21	201
Sta Registr	te ar	31. Date filed (Month Day, Year) AUG 0 22010	32. Registrar's Si	gnature	areen St				

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician Month Florence Rose Sukhdeo A M 2010 29 4:11 July /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Cheverly Prince George's Prince George's Hospital Center 8. Date of Birth (Month, Day, Ye June 13, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** ^{Year} 1938 1 □ M 2 🕇 F Days Hours Months Gŭÿä'na None 72 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or than "natural", or items 23a or 28a-f show 1 □Yes 2 No Director N/A N/A East Coast Demerara, Guyana 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number N/A Guyana 97 Better Hope North Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: à 3 ☐ Widowed 4 ☐ Divorced Asian Indian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry of Health and Mental Hygiene. item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) University of Guyana Professor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Millicent Armogan Cecil Ledra ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rupert Sukhdeo / Spouse 97 Better Hope North, East Coast, Demerara, Guyana other 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If its any Injury or o once. 1 ☐ Burial 2 💆 Cremation 3 🖾 Removal from State Fresh Pond Crematory 8/2/2010 4 ☐ Donation 5 ☐ Other (Specify) Middle Village, NY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 23a. Part 1. Exper the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause are each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MATA /Medical Due to (or as a consequence of): Examiner CONCESIONE Sequentially list conditions, Examiner Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed and burial-trar Due to (or as a consequence of): attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 5 Other (specify) P.0. signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 24 No 1 ☐ Yes Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral (27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 ☐ Pending investigation n 24 hours after death.

e Funeral Director Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the I 29b. Signature and title of certifi-29c. License number 10083703 on who completed cause of death (Item 23a) (Type, Print) FAL DR Cheverly mp 20785 2. Registrar's Signature State Registrar

		Please	State of Ma				re All Copies and Mental Hy	_		
		for State	State of Ma	•	epartment of Certificate o		anu wentai ny	- Z U	10 2	25736
	-	Registrar 1. Decedent's Name (First, Middle, L	.ast)			, Dodin	2. Date of D			Time of Death
Physic /Med		Alfred I. Spiele	er				0 ^{Month} 29	20ÎÖ	Year 2	1:43 PM
Exam		4a. Facility Name (If not institution, g	rive street and number)		4b. City, Town	, or Location o	f Death	4c. County of	of Death	
-		19 Hidden Lake (Ocean I		24 1 1 2 2 2 2 2 2	Worces		(0)
Funera		5. Social Security Number 6. 044–28–7799	Sex 7. Age 7. Age 7. Age 7. Age 7.	e (In yrs. last birtl R	nday) If Under 1 Year Months Day		Min. 08 31	1931 N	9. Birthplace Country) Massach	(State or Foreign
Directo		Usual Residence of Decedent					00 02		.abbaa.	
rylan	_	10a. State 10b. County		10c. City, Town	or Location					nside City Limits
e Ma Sa-f s	Director	Maryland Worcest	er	Ocean P				40		Yes 2 No
with th	Ę	10e. Street and Number			10f. Zip Cod	е		10g. Citizen of W	mat Country?	
infled within 72 hours after death with the Maryland filled within 72 hours after death with the Maryland Hygiene. therefore in the maryland Eventine must be notified at any the Walfad Eventine must be notified at	Funeral	19 Hidden Lake Co	12. Was Decedent E	ever in U.S.	21811 13. Was Decedent of	of Hispanic Orig	gin? (Specify Yes or N , Puerto Rican, etc.)	USA o- 14. Race	e - American In	ndian,
or iter	Ţ	1 ☐ Never Married 2 🔀 Married	Armed Forces? 1 XYes 2 □ N		If Yes, specify C 1 ☐ Yes 2 🕱 N		, Puerto Rican, etc.)		k, White, etc.	
ours a	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	Army				Specify:	White	
"natu	Completed	15. Decedent's (Specify only highest of	Education grade co <i>mpleted)</i>	16a.	Decedent's Usual Oc (Give kind of work do life. DO NOT use ret	cupation ne during most irod)	of working	16b. Kind of Bus	siness/Industr	у
withir iene.	dwo	Elementary/Secondary (0-12)	College (1-4or 5	+)	iatrician	neu)		Medical	Doctor	•
e filed Il Hyg other	Be C	17. Father's Name (First, Middle, La.	st)			18. Mothe	r's Name (First, Middle	e, Maiden Surname	9)	
uld be Menta Irked Itic ev	70 B	Edward Spieler				Sophi	e Schwartz			
2 sho and 1 is ma	Ι.	19a. Informant's Name/Relationship		1	,		er or Rural Route Num			le)
and dealth		Janice Spieler Wi	fe				rt,Ocean P	ines, MD		Stato
permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Walfacl Event net must be putilled at		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3		Reth Ts	Disposition (Name of crematory or other parts rael Cemet	olace)	8 01 2010	Salisbur	-	
nit. Pa artme ortant injury		4 □ Donation 5 □ Other (Special Service Lice)		7	22. Name and Ad	dress of Facility	v			-
Ben Dep	1	21. Signatur of Junetal Screen	Som	.()	Hol. Loway	Funera	ĺ Home P.A d.,Sailsbu	rv. Marvl	land 21	804
		23a Part 1. Enter the disease, or co shock, or heart failure. List on	mplications that caused	the death. Do n					App	proximate erval Between
Physiciar	1	Immediate Cause (Final disease or condition	ly one cause on each in	CHE						set and Death
/Medica		resulting in death)	Due to (or as	a consequence o	f):					
Examine	Į.	Sequentially list conditions,	b	ardio	nopar	—				
rted	nine.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence o	1);					
te be executed sician and e burial-transit	Examin	that initiated events resulting in death) Last	C Due to (or as	a consequence o	f):					
ate be nysicia ne bur	ical	•	d							
death certificate attending physi	Physician/Medi	IF FEMALE:								
attend for us	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth 4 Pregnant at	2 Fetal death	3 Ectopic pregn			23d. Date Mor	e of delivery nth Day	Year
the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 ☐ Unknown	time or death	5 ☐ Other (specify	7				
ires that the de signed by the a	by Ph	Part II. Other significant conditions	contributing to death bu	ut not resulting in	the underlying cause	given in Part I.	23e. Did	tobacco use contr	ribute to the ca	ause of death?
w requires been sig should be	ed b	Damphes	on his	droad	ila		1 🗆	Yes 2 No	3 Probably	4 Unknown
law requast been 2 should	plet	Type 2	DW				24a. Wa	s an 24b. V	Were autopsy to	findings available
ding Physician: The h. After this certificate h funeral director, page	Completed	Q.					per 1 □ Yes	formed?	leath?	
ician: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:			Othor	of Death (Check only			
Phys rthis ral dir	12	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatie		patient 3 1 DOA			sidence 6 Othe		
ding th. Afte	tion	Natural 5 Pending 2 Accident investigat	(Month, Day	y, Year) Ir	jury	njury at Vork? I □Yes 2 □ I		, non injury occur.		
of Attending Physician: The law requires that the death certificate after death. Director: After this certificate has been signed by the attending phys in by the funeral director, page 2 should be detached for use as the	ifica	3 Suicide 6 Could not		ury - At home, far	m, street, factory, offic	се	28f. Location	(Street and Number	er or Rural Ro	ute Number,
tal or rs afte	Certification:	4 El Hornicide	building, etc	s. (Opeciny)	·		City of Te	JWII, State)		
To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A	Medical		Physician: To the best caminer: On the basis of	f examination and						
o the ithin 2 o the omple	Med	29b. Signature and title of certifier	and manner sta	itea.	29c. Lic	ense number		29d. Date signed	d (Month, Day,	Year)
10	7) h	20		He	1482	8	7/201	10	
10th		30. Name and address of person wh	no completed cause of d	eath (Item 23a) (Type, Print)		1 0 0	16 11		
1 0		314 Franklin	Are 5	nte (t63 K	arlin	MUC	71211		
S Regis	tate	31. Date filed (Month 1989), fee	010 32 Registra	ar's Signature	haves					
negis	41111			- P. /	7					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SWANSON Medical County of Death
Anne Arundel 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death Examiner Harwood (Hospice of Chesapeake) Mandrin House 8. Date of Birth (Month, Day, Year August 9, If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 216-54-3817 M 2 - F 1948 Director Unknown Usual Residence of Decedent show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ms 23a or 28a-f sho must be notified at Director 1 X Yes 2 No Maryland Prince George's Bowie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20715 Funeral 12601 Craft Lane Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Black, White, etc. 0. 1 X Yes 2 □ No If Yes, Give Year or Dates. Vietnam þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White "natural" 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) 27 is marked other than traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Private Mechanic Unknown Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 7 is marked o ၉ Unknown Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10850 Lanham Severn Rd., Lanham, MD Stephen Kemp - Friend item 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Hanover, MD Ardent Cremation Svc: 8/2/2010 4 Donation 5 Other (Specify) 22. Name and Address of Facility Latimore Funeral Services, P.A. Signature of Funeral Service Licensee 9013 Annapolis Road, Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on dach line Immediate Cause (Final disease or condition ived Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. It is underlying Cause (Disease or linjury that initiated events Examiner Due to (or as a consequence of): burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Box 68760 the attending p IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day Year 1 Yes 2 No ed by the a detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed b 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has ral director, page 2: perform 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medical examiner? **Division of Vital** 26. Place of Death (Check only one) MANDRAN Hospital 1 Tes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 the (Specify Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending e Funeral Director: Aft bleted filled in by the fur M Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after To the Funeral Direct completed filled in by Medical Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Cartifying Nurse Fractioner: to the best of my incomedge. Seek continued at the time. Seek and due to the cause(s) and manner as stated. or ly or a 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

2

Name and address of person who completed cause of beath

31. Date filed (Month, Day, Year)

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 29, ^{Day} 2010 Cynthia Julia Spriggs 1825 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Center Cheverly Prince George's 8. Date of Birth

(Month, Day, Year)

Jan 3, 1969 If Under 1 Year | If Under 24 Hrs. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 □ M 2 🔀 F Months Days Hours Mary Land **Director** 41 216-68-8018 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 93° or 90° or 10 me. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1X Yes 2 ☐ No Maryland Prince George's Landover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7633 Greenleaf Road 20785 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian th- M-dical Examiner Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. Completed by 1 X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) none none To Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ernest Spriggs Florence Harrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; If item 27 is any injury or other trau once. Florence Spriggs (Mother) 7633 Greenleaf Road, Landover MD 20785 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Resurrection Cemetery's /5/2010 21. Signature of Funeral Service License 22. Name and Address of FacilitLatimore Funeral Services, P.A. 9013 Annapolis Road, Lanham MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirate Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day P.O. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably Unknown ours after death.

eral Director: After this certificate has been si filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗌 No 1 🗌 Yes Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital No Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of De th . Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident
Suicide
Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 10. 25739

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) JULY 30,2010 **Physician** EARL 10:00 AM SANDERS JAMES /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** HAGERSTOWN WASHINGTON AUTUMN ASSISTED LIVING 9. Birthplace (State or Foreign Country)
WEST VIRGINIA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year, 5/25/1933) Days 1 ☑ M 2 □ F 77 233-50-9607 Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No WV BERKELEY MARTINSBURG Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 149 LINA LANE 25405 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Xes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: þ 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry RAILROAD 15. Decedent's Education (Specify only highest grade completed) d 2 should be filed within the and Mental Hygiene.
7 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) YARDMAN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be EARL CALVIN SANDERS MARY RUTH SNYDER 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any Injury or other traum once. LYNNE CANBY/DAUGHTER 221 ROBINS LANE, FALLING WATERS, WV 25419 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State PAYNES CHAPEL CEMETERY RIDGEWAY, WV 4 □ Donation 5 □ Other (Specify) 2010 22. Name and Address of Facility 21. Signature of Funeral Service Licensee BROWN FUNERAL HOME, PO BOX 821, Robert 327 W. KING ST., MARTINSBURG, WV 25402 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CHRONIC OBSTRUCTIVE PULMONARY DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine burial-transi resulting in death) Last Due to (or as a consequence of) Box 68760, physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 9☐Unknown Year 5 Other (specify)_ Division or Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ ARTERY DISEASE DIABETES 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed MALLITUS MYPER TENSISON 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autonsy performed? MYPERKIPIDEMIA 1∐ Yes 2 -No 25. Was case referred to medical Be 26. Place of Death (Check only one) AUTURN ASSISTED Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Gother (Specify) 1 ☐ Yes 2 ☐ No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Hospital or Attending 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident 3 ☐ Suicide 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) 000 (8019 -that mo JULY 30 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAGERSTOWN MOZITUS MILL ST an O 3 u o 32. Registrar's fignatur 31. Date filed (Month, Day, Year) AUG 172010 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien & U

25740

1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2010 Stewart Aug 6, 11:50 AM Tina Joy /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 15907 Meadowdale Drive Allegany Rawlings Date of Birth (Month, Day, Birthplace (State or Foreign Country)
 MS 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□ M 2□ F Hours Months Days Min 427-29-2861 Oct 1, Director 46 1963 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. Count 10d. Inside City Limits MD Allegany item 27 is marked other than "natural", or items 23a or 28a-f st other traumatic event, the Medical Examination to motified Rawlings Director 1 □Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15907 Meadowdale Drive 21557 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Milo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 1 □ Yes 2 □ Xio ģ Specify Specify. 3 Widowed 4 X Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Blue Cross Blue Shield billing dept 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Franklin Hicks Carolyn (Harris) Hicks ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 is Carolyn Hicks mother MD 21557 15907 Meadowdale Drive Rawlings 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If it any Injury or conce. 1 ☐ Burial 2 ☐ X emation 3 ☐ Removal from State 8/7/2010 Scarpelli Funeral Home, P.A. Cresaptown MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Sign ture of uneral Service 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1 Enter the disease, or complications that caus shock, or heart failure. List only one cause on each or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Month /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the buri Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 2 1 XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 1 □Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 A Residence 6 Other (Specify) Hospital 1 Yes 2 No မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a, Certifier Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0066150 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 204 ve Sui State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Physician/ Month July 29 0400 Charles Raymond Stubs, Jr Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 208 St. Mark Way Westminster Carroll If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 1 M 2 □ F Nov 16, Year) 930 Washington DC Director 79 577-40-5390 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Examiner must be notified at Director 28a-f Yes 2 No MD Carroll Westminster 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 208 St. Mark Way 21158 USA death y 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. Korean Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 0 1 Never Married 2 Married þ filed within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: "natural", Completed 3 Widowed 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. US Army Elementary/Seconday (0-12) College (1-4 or 5+) Pentagon Budget Analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be other traumatic Charles Raymond Stubs, Sr. Agnes Stone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Peaav Stubs wife 208 St. Mark Wav Westminster, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation Ind 7/30/2010 Hampstead, Maryland Signature of Funeral Service hicensee 22. Name and Address of FacilityPritts Funeral Home & Chapel, PA she V-412 Washington Rd. Westminster, MD 21157 Part MEnter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ disease or condition ment Medical resulting in death) Examiner Sequentially list conditions, if any leading to immediat Examine Due to (or as a nonsequence of) cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical certificate be Box 68760 the SB IF FEMALE nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year detached the 9 Unknown 9 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 Division of Vital Records, 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s After this certificate has autopsy performed 2 🗆 No 1 Yes Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica 25. Was case referred to medical director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes 20 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury Natural 5 ☐ Pending __Investigation 1 Yes 2 No Accident M the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in by determined To the Hospital of within 24 hours a To the Funeral D completed filled in Medical Certifying Physician: To the best of my knowledge, seath occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner or the basis of examination and or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Fractioner: To the best howledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of ceptifier 29c. License number 29d. Date signed (Month. Day, Year) WJL 15 30. Name and address of person who completed cause of death em 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar

			For State Registrer	State of	Maryland .	Depa	artment of rtificate of	Health : f Death	and M		giezeo	0	25742
	Physici	an	Decedent's Name (First, Middle,	Last)				•		2. Date of De Month	ath Day	Year	3. Time of Death
Ų.	/Medi		Miriam P. Schaeff							07	25 2	010	11:00 A M
	Examir	er	4a. Facility Name (If not institution,		ber)		4b. City, Town,		of Death		4c. County		
Н	Francis		Longview Nursing 5. Social Security Number 6		. Age (In yrs. last	hirthday)	If Under 1 Yea	hester	24 Hrs.	8 Date of Bir	Carro		UNTY place (State or Foreign
Н	Funeral Director		212-16-9247	1□M 2XF	88	Yrs.	Months Day		Min.	8. Date of Bir (Month, Da 03/22/1	y Year) Q22	Cou	sylvania
	P. ,		Usual Residence of Decedent							_05/22/1	JEE	I CIHI	· ·
	show	7	10a. State 10b. County		10c. City, T	own or Lo	cation						10d. Inside City Limits 1 Wes 2 ☐ No
	the M	ectc	MD Carrol 10e. Street and Number	1	Ma	nches:		_					
	with	Funeral Director	3332 Main Street				10f. Zip Code 21102				10g. Citizen of V		intry?
	deeth	era	11. Marital Status	12. Was Deced	dent Ever in U.S.	13.1			igin? (Spec		United Sta		can Indian,
9	after o	Fun	1 ☐ Never Married 2 ☐ Married	Armed Ford	ces? 2√∏No	1	Was Decedent of f Yes, specify Cu			Rican, etc.)	Blac	k, White	, etc.
8	ours a	d by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Da	tes:		1□Yes 2D(N	o Specify:			Specify	<i>':</i>	White
<u>2</u>	"natu	Completed	15. Decedent's (Specify only highest	Education grade completed)	1	6a. Deced (Give	dent's Usual Occi kind of work don DO NOT use retir	upation e during mos	t of workin	g	16b. Kind of Bu	ısiness/Ir	ndustry
2	withir ene. than	дш	Elementary/Secondary (0-12)	College (1-	4or 5+)		emaker	red)			Own H	~	
<u>0</u>	filed Hygi other ent, I	Be Co	17. Father's Name (First, Middle, La	st)		TMI	CHUNCI	18. Mothe	er's Name	(First, Middle,	Maiden Sumam		
lan	uld be Aenta rked tic ev	To B	Walter M. Yost					E	lsie M	. Wentz			
Maryland 21215-0036	2 sho and to is me		19a. Informant's Name/Relationship								er, City or Town,	State, Zij	p Code)
<u>رة</u> 1	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylend Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or iteme 23s or 28s-f show any injury or other traumatic event, the Medical Evandary Indust be notified at once.		Roland E. Schaeffer 20a. Method of Disposition	/ Son			rfield Cir	cle, Ha		PA 1733	31 20c. Location -	City or T	aum Stata
altimore,	ages ent of it: if it y or o		1 XX Burial 2 ☐ Cremation X '4 ☐ Donation 5 ☐ Other (Special	Removal from S	ceme	etery, crer	natory or other pl Church Ce	ace) emeterv			Hanover,		OWII, State
a E	mit. Partme partme porter 7 Injur 28.		21. Signature of Funeral Service Lice										
<u> </u>	88 11 8		191.1=		CC 0354	Ke	nworthy Fi	uneral H	lome, .	Inc., 26	9 Frederio	ck Str	Seet, Hanover
	- 11		23a. Part1. Enter the disease, or co shock, or heart failure. List on	ry one cause on ea	ch line.	o not ent	er the mode of dy	ing, such as	cardiac or	respiratory ar	rrest,		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Other	osclero	tic (Cerebra	ovasc	ulor	-Dis	reasl		Onset and Death
	Examiner			Due to (o	r as a consequent	ce of):							
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (o	r as a consequenc	ce of):							
	ecuted and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										
8760,	deeth certificate be executed e ettending physicien and id for use as the burial-transit		and the second s	Due to (o	r as a consequend	ce of):							
687	tificate og physi as the b	edical		d									
Box	eeth certif ettending for use as	M/UI	IF FEMALE: 23b. Was decedent pregnant		ome of pregnancy		I=				23d. Dat	e of deliv	ery
		Physician/Me	in the past 12 months? 1 🗆 Yes 2 🕦 No		nt at time of death		Ectopic pregnan Other (specify) _	су			Moi	nth	Day Year
л О	hat the de d by the e letached f	Phy	9 Unknown			- !				on- Dida			
Kecords,	requires that the teen signed by th	Completed by	Part II. Other significant conditions Sementia	contributing to dea	an but not resulting	g in the ur	ideriying cause g	iven in Part I.	•		4/		he cause of death?
Ö	> 40	iete	Orteran	10									
Ě	The law cate has b page 2 si	дшс	- Chargo wo								rmed?	rior to co leath?	opsy findings available ompletion of cause of
Vital	ician: Th certificate rector, pag	a l	25. Was case referred to medical					26 Place	of Dooth	1 ☐ Yes (Check only o		☐ Yes	2 No
	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ② No	Hospital:	patient 2 ER/	Outpatien	t 3□ DOA O	thon /			dence 6 □Othe	er (Specii	fv)
n or	ding Ph h. After th funeral		27. Mann → of Death 1 Natural 5 □ Pending	28a. Date of (Month)	Injury 28t	. Time of	28c. Inju				now injury occurr		,,
20	Attending ar death. rector: After by the fune	cati	2 Accident investigate 3 Suicide 6 Could not	be			M 1	Yes 2					
UIVISION	si or Atten after deat I Director: d in by the	Certification:	4 Homicide determine	d 286. Place o	f Injury - At home, , etc. <i>(Specify)</i>	farm, stre	et, factory, office		28	Bf. Location (S City or Tox		er or Rura	al Route Number,
			29a. Certifier 1 Certifying F	Physicien: To the b	est of my knowled	lge, death	occurred at the t	time, date an	d place, ar	nd due to the	cause(s) and ma	nnerass	tated.
	To the Hos within 24 ho To the Fun completely	edical	(Check only 2 Medical Executed Medical E	eminer: On the bas and manne	is of examination :	and/or inv	estigation, in my	opinion, dea	th occurred	d at the time,	date and place, a	ind due to	o the cause(s)
	To the within 2. To the complet	Ž	29b. Signature and title of certifier	2 2 1	_	^		nse number			29d. Date signed	(Month.)	Day, Year)
	WIL		Fracel	Z- Rybe	ig, D	.0.		0061.			7/2	+/	10
	10		30. Name and address of person who	completed cause		tmi.	WSTOD	racie-	L. Ry	berg D	.0.		
	Stat	е	31. Date filed (Month, Day, Year)	32. Reg	strar's Signature	C17(11	- GCC/	7 11		1101			
	Registra	_	.111 2 9	2010	- accord	A	books						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 26 per Phy. 07/27/10 Carroll Co., will
State of Maryland / Department of Health and Mental Hygiene. For State Registrar 25743 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ju^{Month}_{u} 2^{Day} 2ďľ0 9:50 P M Marjorie Robinson Stewart Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Westminster Carroll Hospice Dove House If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign . Age (In yrs. last birthday **Funeral** 1 □ M 2 🛣 F June 17, Year) Months Hours Min. Virginia Director 88 229-12-4691 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Westminster Maryland Carroll 1 Yes 2 No 10e. Street and Number 10f. Zip Code ms 23a or ò 10g. Citizen of What Country? Funeral 21158 USA 200 St. Luke Cr. items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ö þ 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify: Specify: White "natural" Completed 3 ☑ Widowed 4 ☐ Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the Own Home 12 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill of Health and Mental item 27 is marked of မ Linwood Robinson Mary E. Page 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 251 Bell Rd., Westminster, MD 21158 Steve Stewart/Son Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 1 X Burial 2 Cremation 3 X Removal from State cemetery, crematory or other place) Newport News, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Peninsula Mem. Park 7/28/2010 Signature of Funeral Service Licensee Britts fineral Home and Chapel, P.A. all 412 Washington Rd., Westminster, MD 21157 23a. Part . Ent the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ discas Carenan disease or condition resulting in death) green Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☑ No Month the 1 ☐ Yes 2 ₾ 9 ☐ Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed certificate 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 40 Other: 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA -5 ☐ Residence 6 🛛 Other (Specify) Hospice To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 No ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 👱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 7/26/10 D8050163 WJL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Washington RL. St 120 Wostminsten MD 21157 826 Mordoza 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 20 TO AnuEL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NOUCESTER GEN. HOSP BERLIAS ATLUANTIC If Under 1 Year If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🕅 M 2 🗆 F Months Days Hours Min. (Month. Day, Year, 205-20-8880 Director 79 _1930 MD Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State with the Maryland Director 1 Yes 2 No Pocomoke City Worcester 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1210 Market St 21851 Apt C4 12. Was Decedent Ever in U.S. permit. Page 1 and 2 should be filed within 72 hours after death 1 Der artment of Health and Mental Hyglene. Innroctant: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muonge. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mechanic Dinges Auto Shop Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ William T. Smith <u>Susie Jane Powell</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Priscilla Rounds/Niece 108 Riversiãe Orive, Salisbury, MD 21801 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Paul's Cem 8-7-2010 Berlin, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Bennie Smith 917 *.7 • v Isabella St. Salisbury, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician/ engest Medical Due to (or as a consequence of): Examiner 151 Esquentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) physician and sthe burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) Yes s been signed by the s should be detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 □ Probably 4 □ Unknown 1 🗌 Yes Vasuler Gusea 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) funeral director, **Division of Vital** Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: ၉ Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred al or Attending P s after death. I Director: After t d in by the funers 1 Natural 5 Pending 2 🗌 No Accident Suicide Investigation 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 2010 8n DANG 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

BR

31. Date filed (Month, Day, Year)

50

3.0

 S_{I}

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 7/30/2010 Roslyn Thompkins 13:50 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Washington Adventist Hospital Takoma Park 5. Social Security Number 7. Age (In yrs. last birthday) 62 yrs If Under 24 Hrs. Birthplace (State or Foreign Country) GA If Under 1 Year 8 Date of Birth **Funeral** 1 □ M 2 🕇 F Days Min. Hours 4/97/1948 ar Director 260-82-0255 Usual Residence of Decedent 28a-f shov er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Silver Spring Montgomery 1 X Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? by Funeral 1111 CHickasaw Drive 20903 within 72 hours after death with **USA** 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Black If Yes, Give Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry al Hygiene. I other than " Administrator College (1-4 or 5+) Elementary/Seconday (0-12) Government Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental is marked o မ Nelson Henry Hettie Houston 19a. Informant's Name/Relationship (Type, Pnint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 Tiona Thompkins/daughter 2600 Queens Chapel RD #809 Hyattsville, MD 20782 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ō Burial 2 Cremation 3 Removal from State Cheltenham Cemetery 8/9/2010 CHeltenham, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Bianchi 814 Upshur ST NW Wash., DC 20011 Signature of Funeral Service L 23a. Part 1. Enter the disease omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate nly one cause on each lin Interval Between Onset and Death shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Pregnant at time of death 9 Unknown Records, P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 🗌 No 3 🗌 Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 page this certificate 2 No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 X No 1 Yes မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural work?
1 Yes 2 No injury 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

who completed cause of death (Item 23a) (Tyge, Print)

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ $\underline{0} \, \underline{1}^{\mathsf{a} \mathsf{y}}$ 80 2010 M 11 Α Michael L. Thomas Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 213 S. Frederick Jefferson St. Middletown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X**XM 2 □ F Hours Min. 3^M71th5^D7^y1^Y9^r51 $MD^{(ry)}$ 59 Director 220-54-4494 Usual Residence of Decedent 28a-f shov 10a. State event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Frederick Middletown MD 1 X Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral 23a Jefferson St. 21769 213 S. USA items 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 🛭 Yes 2 🗆 No 1969 Black, White, etc. perruit. Page 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give 3 Widowed 4 X Divorced 1969 Specify: White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) none none Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Edgar Dale Thomas Margie Stevens 19a. Informant's Name/Relationship (Type, Print) Half-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dixie Eichelberger(Niece) <u>206 W. Main St., Middletown, MD 21769</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 8/4^{pt}2010 remetery, crematory or other place) 8/4
Pleasant View Cemetery 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Jefferson, ^{22.}Donald B. Thompson Funeral Home POB 18, Middletown, MD 21769 ert 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Due to (or as a conservence of): Onset and Death Physician, disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the huneral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant 9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death 2 No g Unknown as been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🖪 No Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Comes Bom MD 16939 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) O5H.3+1 31. Date filed (Month, Day) gistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 25717

		•	1 - State Amended #8 per FH, Registrar Amended #5 per FH	RG FCHD , RG FCH	8/5/1 D 8/26	t ific ate of E	Death	,	Reg. No	. <u> </u>	23141				
	Dhamisis	/	Decedent's Name (First, Middle, Last)					2. Date of De Month			3. Time of Death				
	Physicia Medic		RAYMOND WAYNE	THOMS	EN			JUĽŸ	29	2010	12:43A M				
	Examin	er	4a. Facility Name (if not institution, give street and num				Location of Death			County of Deat					
	E	-	FREDERICK MEMORIAL HOS 5.503LS30ty7236 6. Sex	PTTAL 7. Age (In yrs. la:	st hirthday)	FREDER	LCK. If Under 24 Hrs.	#. Date of Bir		FREDERIC 934 g. Birt	hplace (State or Foreign				
	Funeral Director		203 30 7236 1 X M 2 □ F	76	Yrs.	Months Days	Hours Min.	July 2		934 Sốu	ith Dakota				
	d sow	Ļ	Usual Residence of Decedent 10a. State 10b. County	10c City	Town or Lo	cation					10d. Inside City Limits				
	arylan a-fsh fied a	cto	Maryland Frederick	100.00,	, TOWN OF LO		erick				17√2 Yes 2 □ No				
	or 28	Dire	10e. Street and Number			10f. Zip Code	ELICK	Т	10g. C	tizen of What Co					
	s 23a nust be	Funeral Director	1339 Butterfly Lane			2170	3			United	States				
	death r item ner n		Armed Fo	edent Ever in U.S.	52 –	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Ame Black, White					
036	be filed within 72 hours after death with the Maryland ental Hygiene. Aged other than "natural", or items 23a or 28a-f show ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at.	ed by	1 ☐ Never Married 2 ☐ Married 1 ☑ Yes 3 ☒ Widowed 4 ☐ Divorced Year or D	e 10		1 ☐ Yes 2 🛣 No	Specify:				Thite				
Maryland 21215-0036	2 hour "natu dical	Completed	15. Decedent's Education (Specify only highest grade completed			dent's Usual Occupa		dina	16b. F	Kind of Business	Industry				
121	ithin 7 ene. than he Me	Som	Elementary/Seconday (0-12) College (1			O NOT use retired) Foreman	Ů	Ü	l ,	Asphalt	& Concrete				
0 0	led wi Hygie other ent, t	Be	17. Father's Name (First, Middle, Last)			101011111	18. Mother's Nan	ne (First, Middle,			00110100				
lan I	0 = 9 0	မ	Wendell Thompson				Li	Ly Thoms	sen						
an)	2 should be the substitution of the substituti		19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	ng Address (Street a	and Number or Rui	al Route Numbe	er, City o	r Town, State, Zip	Code)				
<u>د</u> د	and 2 Health em 27 ther tr		Debora Elsey / Daughter			Griffith	Way, Fre								
סר	Page 1 annument of Hannument of Hannument of Hannument of Mannument of		20a. Method of Disposition 1 A Burial 2 Cremation 3 Removal from	State 205. Pl	ace of Dispo emetery, crer	sition (Name of matory or other plac	· 1	Date		ocation - City or					
Baltimore,	permit. Page Department of Important: If any injury or once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	Mt	. 01iv	7et 2. Name and Addres		2010		ederick. r Funera	Maryland				
B	permit. Departn Imports any injt	d	1 our tries Sto.	1 lber											
			23a. Rack. Enter the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lest only one cause on each line. Approximate Interval Between Onset and Death												
- F	h, sician/	0 8	Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):												
	Medical Examiner		resulting in death) Due to	(or as a conseque	ence of):										
		Jer	Sequentially list conditions, if any, leading to immediate Due to	(or as a conseque		24									
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events C												
	icate be executed g physician and is the burial-transit	E E	resulting in death) Last Due to	(or as a conseque	ence of):										
3/60	ate be ohysic the bi	Medical	d												
200	± 0, a	_		come of pregnan						23d. Date of de	livery				
NO S	eath c e atter d for u	Physician/	in the past 12 months?	Birth 2 Fetal nant at time of de		_ Ectopic pregnand Other (specify)	У			Month	Day Year				
P.O.	t the d by the tacher	Phys	g Unknown												
<u>7.</u>	s tha gnec	by	Part II. Other significant conditions contributing to c	eath but not resu	liting in the t	inderlying cause giv	ren in Part I.				the cause of death?				
rds	requir been s should	letec						24a. Was			topsy findings available				
ວ	≥ 000	Completed						auto	psy ormed2	prior to death?	completion of cause of				
<u> </u>	sician: The lav certificate havirector, page 2	O	25. Was case referred to medical			26. Pla	ace of Death (Chec	1 🗆 Yes	2 9 N	o 1 L Yes	3 2 □ No				
7	nysici nis cer I direc	To B		Inpatient 2 🗆 E	ER/Outpatie	nt 3 🗆 DOA Othe	er: 4 Nursing H	ome 5 🗆 Resi	dence (6 Other (Spec	ify)				
ס ר	ling Pl		Natural S Li Feliulig	of injury th, Day, Year)	28b. Time of injury	work	?	28d. Describe h	now inju	ry occurred					
SIO	ottend death ctor: / y the i	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	of Injury - At hor	me. farm. str	M 1 L	Yes 2 No	28f Location (Street ar	nd Number or Ru	ral Route Number,				
DIVISION	alor A s after of Directory	Cel	4 Homicide determined 28e. Place build	ng, etc. (Specify)	,,	, , ,		City or Tov							
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	29a. Certifier 1 Certifying Physician: To the ba	est of my knowle	edge, death	occured at the time,	date and place, a	nd due to the ca	use(s) a	nd manner as sta	ated. cause(s) and manner stated.				
	the thin 2, the F	Me	only one) 3 Certifying Nurse Practioner: 29b. Signature and title of certifier				time, date and pla		e cause	s) and manner as	stated.				
	5 W 1 W		Dospital	st					-	ate signed (Month	i, vay, 10a)				
	1		30. Name and address of person who completed cause		23a) (Type, F	Print)	674070 ruk		//	CILL					
JC	TIVA		SAFRINA HASA	W	FMH	, Freder	ruk								
	Stat Registra		31. Date filed (Month, Day, Year) 32. F	legistrar's Signatu	27.7	booked									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Aug. **Physician** C. Wesley Taylor, Sr. 20To 0800 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Preston

| Funder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept. 14, 1925 4734 Newton Road Caroline Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 ☐ F 215-36-1718 84 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location d other than "natural", or Items 23a or 28a-f show event, I'm Medical Examinar must be notified at 1 ☐ Yes 2 No Director MDCaroline Preston 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4734 Newton Road 21655 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐Yes 2**X**☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married 2X XVo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 11 (Grad.) College (1-4or 5+) Cattle/Agriculture Livestock & Grain Farmer permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiens Important; If item 27 is marked other that any injury or other traumatic event, Insulores. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Noble Taylor Flora Williamson ္ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Calvin W. Taylor, Jr./Son 4671 Newton Road, Preston, MD 21655 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 DXBurial 2 ☐ Cremation 3 ☐ Removal from State Grove Cemetery Preston, Maryland 08/06/10 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, P.A. 21. Signature of Funeral Service Licensee 216 N. Main St., Federalsburg, MD 21632 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause and line. Immediate Cause (Final disease or condition resulting in death) **Physician** aneventic 8 months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician; The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) detached 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 □ Yes 2 No certificate 1 ☐ Yes 2 ☐ No : After this certifics e funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director; A investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

State Registrar

DHMH 17 Rev 1/2001

completely

30. Name and address of person who co

29b. Signature and title of certifier

509

31. Date filed (Month, Day,



cause of death (Item 23a) (Type, Print)

and manner stated.

232

29d. Date signed (Month, Day, Year)

2010

DHMH 17 Rev 1/2001

Registrar

			State of Man				nd Mental Hy	giene	10	25750				
			Registrar 1. Decedent's Name (First, Middle, Last)	Cer	tificate of D	eath			10					
	Physicia		MARTHA VIRGINIA TODD				2. Date of De Month JULY	_	ořő	3. Time of Death 2:15 A M				
	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b, City, Town, or	Location of D		4c. County		2.13				
	LXamiii		ANNE ARUNDEL MEDICAL CENTER		ANNAPOL	IS			ARUN	DEL				
	Funeral		1 DM ONE	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hours		th	9. Birthpl	ace (State or Foreign				
	Director		219-40-8440	67 Yrs.			JUNE 1	, 1943	MARY	GAND				
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	tor		c. City, Town or Lo	cation				10	d. Inside City Limits				
		irec		STEVENSVI	LLE					1 Yes 2 X No				
	h the	Funeral Director	10e. Street and Number		10f. Zip Code			10g. Citizen of V		•				
	ms 2; must	ner	223 BALTIMORE ROAD 11 Marital Status 12. Was Decedent Ever	in 116 112 1	21666	anania Origini	? (Specify Yes or No-	UNITED						
(0	or ite	by Fi	11. Marital Status 12. Was Decedent Ever Armed Forces? 1 ☐ Never Married 2X Married 12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 X No	10.5.	f Yes, specify Cuba	n, Mexican, P	uerto Rican, etc.)	Blac	e - America k, White, et	tc.				
21215-0036	rs afte ural", Exar	ed k	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1	☐ Yes 2 🛣 No	Specify:		Specify:	WHI	re				
ر ا	2 hou "natu adical	Completed	15. Decedent's Education (Specify only highest grade completed)		dent's Usual Occupa		working	16b. Kind of Bu	usiness Indi	ustry				
121	thin 7 ene. • than he Me	Som	Elementary/Seconday (0-12) College (1-4 or 5+)		O NOT use retired) MAKER			OWN HOL	ME					
d 2	led wi Hygie other ent, t	Be	17. Father's Name (First, Middle, Last)	пол		18. Mother's	Name (First, Middle,							
<u>lan</u>	d be fi Jental Irked Itic ev	1	JAMES COOPER			MA	RTHA HANS							
Maryland	should and N is ma auma	, l	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street a	and Number o	r Rural Route Numbe	r, City or Town, S	tate, Zip Co	ode)				
ა :	and 2 Health Im 27 her tr	1	PHILLIP B. TODD			ROAD,	STEVENSVI							
Baltimore,	ge 1 a nt of H : If ite or ot		1 Burial 2 To Cremation 3 Removal from State	20b. Place of Dispo	CREMATO	ion Ju	LY 30,	20c. Location -						
Ē.	nit. Pa artmer ortant injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euperal Solvice Licensee	CENTE	ER, LLC	20	010			, MARYLAND				
Ba	Department of the control of the con		1. V MI 16/1	ren 10	LLOWS, H	ELFENB CK_ROA	EIN & NEWN D, CHESTER	AM FUNE	RAL HO	OME, P.A. 21619				
			23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.			-		rest,		Approximate Interval Between				
- P	nysician/ Medical	9	resulting in death)	stridium	Dittio	tile Le	olitis			Onset and Death				
-	Examiner		Due to (or as a co	onsequence of):										
		ner	Sequentially list conditions, if any hadding to immediate	onse trience of).										
1	are be executed hysician and the burial-transit	Examiner	cause. Enter Underlying Cause (Cisease or linjury that initiated events c.											
	e exection ar sian ar urial-ti	al E	resulting in death) Last Due to (or as a consequence of):											
8	the bi	edical	d			***								
89	earn cerunicat attending ph for use as th	by Physician/Me	IF FEMALE: 23c. If yes, outcome of p					23d Dat	te of deliver					
Š	earn o	icia	in the past 12 months? 1 □ Live Birth 2 L 1 □ Ves 2 🕅 No. 4 □ Pregnant at tin		Ectopic pregnanc Other (specify)	У		Mo		Day Year				
о. Н	requires that the de been signed by the should be detached	hys	9 Unknown 9 Unknown											
<u>G</u>	igned be de	by I	Part II. Other significant conditions contributing to death but r	ot resulting in the u	nderlying cause giv	en in Part I,		obacco use contr						
rds	equire	eted								ably 4 🗆 Unknown				
ဝ၁	has b	Completed					24a. Was auto	osy F		sy findings available pletion of cause of				
<u> </u>	sician: The law certificate has b lirector, page 2 s		25. Was case referred to medical		26 Pla	age of Death (1 ☐ Yes		I ☐ Yes 2	2 □ No				
Vita	ysicia is cert direct	To Be	examiner? 1 ☐ Yes 2 🔀 No Hospital: 1 💢 Inpatient	2 ER/Outpatien	1	er:	ng Home 5 🗆 Resid	tence 6 \(\text{Othe}	er (Specify)					
jo g	fter th		27. Manner of Death 1 Natural 5 □ Pending (Month, Day, Ye	28b. Time of	28c. Injury work'	at		ow injury occurre						
ion	death.	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be		M 1 🗆	Yes 2 No								
Division of Vital Records, P.O. Box 687	after Direc	Çe	4 Homicide determined 28e. Place of Injury - building, etc. (S	At home, farm, stre pecify)	et, factory, office		28f. Location (S City or Tov	Street and Numbe in, State)	er or Rural F	Route Number,				
L	within 24 hours at a treatming tripstrain. The law requires that the beam certificate be executed. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 🔀 Certifying Physician: To the best of my	knowledge, death o	ccured at the time,	date and place	ce, and due to the ca	use(s) and manne	er as stated					
he H	hin 24 the Fu Tplete		(Check 2 ☐ Medical Examiner: On the basis of exam only one) 3 ☐ Certifying Nurse Practioner: To the best	ination and/or invest	igation, in my opinio	 n, death occur 	red at the time, date a	nd place, and due	to the caus	se(s) and manner stated.				
Ē	To Con	- 1	29b. Signature and title of continer Special Bell Mi		29c. License	11 Ca		29d. Date signed		ay, Year)				
	19 Wis		3 Faction, 101		1	40052		71	29/10					
	(1,		30. Name and address of person who completed cause of death Sire Blub, two 2001 31. Date filed (Month, Day, Year) 32. Registrar's 32.	(Item 23a) (Type, P	Parkway	ania	polo MO							
	State	е	31. Date filed (Month, Day, Year) 32. Registrar's	Signature	,		•							
	Registra	r	JUL 30 2010 Deneus	U B. A	are									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Smith Ada Tyndall 2010 August 12:15 p^M⋅ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death John B. Parsons Home Salisbury Wicomico 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Year 927 July 9, Director 220-22-2245 Maryland 83 Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director MD Wicomico Salisbury 1 A Yes 2 □ No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 300 Lemmon Hill Lane 21801 USA 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. ò 1 Yes 2 No
If Yes, Give
Year or Dates. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after "natural", 1 ☐ Yes 2 X No Specify: white Completed 3 XWidowed 4 Divorced ulth and Mental Hygiene. 27 is marked other than "natur r traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) owner/operator coin shop Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Charles R. Smith Page 1 and 2 should be ment of Health and Menta Mabel Nittinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William E. Tyndall son 5734 Linkwood Rd, East New Market, MD Department of Health Important: If item 27 any injury or other th 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Wicomico Memorial Park 8/5/10 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) sequence of **Examiner** Sequentially list conditions, ner tany leads of to himedat cause. Enter Underlying Cause (Disease or linjury that initiated events Date for Contra Exami been signed by the attending physician and should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death Month Year 4 Pregnant 5 Other (specify) 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Yes 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eral Director: After this certificate has filled in by the funeral director, page 2 s autopsy performed 2 🗌 No Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 2/ No Hospital 1 🗌 Yes Other: မ 1 Inpatient 2 Inpatient 3 Inpa 4 ☐ Nursing Home 5 ☐ Residence 6 🖾 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural work Accident 1 Tes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined within 24 hours a To the Funeral L 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

Name and address of

completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 25752 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Mildred Viola nomas 2010 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Nilliam Hill Manor Nursing Home aston Talbot If Under 24 Hrs. ecurity Number 7. Age (In yrs Jast birthday) If Under 1 Year 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗷 F 216-82-0312 Months Days Min Director land Mary Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No talbot t. Michael 10e. Street and Number 10g. Citizen of What Country? Funeral 504 21663 N. Talbot 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 IV No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Şeconday (0-12) College (1-4 or 5+) Convenience ntrepreneur Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Surname) မ urrai 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Washington Grant 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 200 Location City or Town, State 1 De Burial 2 Cremation 3 Removal from State 110 Thomas Men, Cemeter 4 Donation 5 Other (Specify) 22. Name and Address of Facility
HENRY FUNERAL HOME, P.A.
510 Washington St. Com

Stock of Company of Company of Company of Company
Stroke of Company of Company of Company
Stroke of Company of Company
Stroke of Company of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Company
Stroke of Compan 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final STACOK Onset and Death EMENTIA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) ending physician and use as the burial-transit law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) the attending physician Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day Pregnant at time of death Month Year been signed by the should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? BILATERAZ 16269ROUSSLYLAR 1 Yes 2 No 3 Probably 4 Nnknown HYDUCZENSION 24b. Were autopsy findings available prior to completion of cause of death? this certificate has autopsy page performed? Hospital or Attending Physician: The 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined To the Hospital within 24 hours a To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 ☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) ss of person who completed cause of death (Item 23a) (Type, Print) Brownubback 321 41 MBOLD M 31. Date filed (Month, Day, Year) State

Registrar

Baltimore, Maryland 21215-0036

Box 68760

Records,

Division of Vital

10-05544

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2010 25753 Carlton H. Tiffany State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Rea No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Month Carlton Howard Tiffany 2125 hrs Medical Examine July 24, 2010 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death c. County of Death Caroline 11350 Gregg Road 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** 365-96-4462 Months Days Hours Min 41 4/05/1969 Director Country MI. 1 XM 2 F Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a, State 10b. County imore, MD 21215-0036
Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once. MD Caroline 1 X Yes 2 No Denton Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11350 Gregg Road 21629 USA Funeral 11. Marital Status

1 Never Married 2 Married Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. White, etc. Armed Forces? $_{2}|\mathbf{X}|$ __ Yes White Divorced If Yes, Give Year 1 Yes 2 No specify: δ 16a. Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Landscaper Landscape Co. 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Clifford Howard Tiffany Be Mae Marie Goupell J 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zin Code) 4888 19a. Informant's Name/Relationship (Type, Print) Clifford H.Tiffany/Father 12205 Hart Road N.E.Lot.5 Greenville,MI 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State timore. 2 Cremation Burial 3 Removal from State Chesapeake Crem. 7/28/2010 Beltsville,Md re of Funer PHILIP O'D'S RIWALDI FUNERAL SERVICE, P. A 9241 Columbia Blvd.Silver Spring, Md2091(disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** een Onset and failure List only one cause on each line. /Medical Death a Intraoral Shotgun Wound Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last n and - transit The law requires that the death certificate be executed ca g physician a the burial -AMENDED UNPENDED Physician/Medi Box 68760, IF FFMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year this certificate has been signed by the attending I director, page 2 should be detached for use as i Live birth Fetal death Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Unknown Completed of Vital Records, 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed? death? 1 🗸 Yes ✓ Yes 2 No Hospital or Attending Physician: 26.Place of Death (Check only one) 25. Was case referred to medica Be Other₄ examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 🗸 Other: Scene 2 2 No 1 🗸 Yes 28a. Date of Injury (Month, Day Year) Jul 24, 2010 After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Subject shot self Natural 2105 hrs Division 1 Yes 2 V No Pending death. the To the Funeral Director: Accident Investigation filled in by 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 V Suicide 6 Could not be or Town, State) 11350 Gregg Road, Denton, Md determined (Specify) Single Family 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 24] 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 25, 2010 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Day Year) 32 Registrar's Signature State

Registrar

10-05964 Jena Thomas Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Jena Thomas		State of Maryland / Depart 1-For State Certi Registrar	tment of <i>ficate of</i>		d Mental H	-	2010 eg. No.	25/54
Physicia Medical Examin	n/	1. Decedent's Name (First, Middle,Last) Jena Meredith Thomas				Date of Deat Month	h Day Year	3. Time of Death
Bredical Examin		4a. Facility Name (if not institution, give street and number) 1839 Town Point Road		tb. City, Town, or Cambridge	Location of Death	August 8,	4c. County of Death	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last 212–08–9594 1 M 2 X F 29	t birthday) Yrs.	If Under 1 Year Months Days		-	Co	thplace (State or Foreign untry) Maryland
d how any	1	Usual Residence of Decedent 10a. State 10b. County 10c. City, To	own or Locati	on Cambr	idge			10d. Inside City Limits 1 Yes 2 X No
the Maryland a or 28a-f show	Director	10e. Street and Number 1839 Town Point Road		10f. Zip Code	21613	10	og. Citizen of What Coul USA	ntry?
	by Funeral	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year or Dates: 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give Year 17 Yes, Give Year 18 Yes, Give Year 19 Togates:)f Ye	s Decedent of His es, specify Cuban Yes 2 X No	, Mexican, Puerto specify:	Rican, etc.)	White, etc. Specify:	
1036 aithin 72 hours ene. er than "natu	mpleted	Elementary/Secondary (0-12)	vork done red)	public s	•			
21215-0036 buld be filed within 7 Mental Hygiene. marked other than cevent, the Medica	æ	17. Father's Name (First, Middle, Last) David Chase Thomas Jr.	aldwin					
MD 2 should alth and M mm 27 is m m 27 is m raumatic e	۵[19a. Informant's Name/Relationship (Type, Print) David C. Thomas Jr. father	5439	Town Poi	nt Rd.,		ber, City or Town, State lge, MD 216	513
Baltimore, permit. Pages I an Department of Helimportant: If ite important: If ite injury or other tr		1 X Burial 2 Cremation 3 Removal from State Anti	matory or oth och Ch	ner place) nurchyard	1 8,	/12/10	Cambridge	e, MD
		21. Signature of Funeral Service Licensee 23a. Part I. Enter the disease, or complications that caused the death. D	70	0 Locust	St., Ca	ambridge		
Physician /Medical Examiner		failure. List only one cause on each line. Cardiac arrhyt Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):		ie mode or dyring, s	Such as calculate o	respiratory arre	St, Shock, of Healt	Between Onset and Death
	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated						
50, te be executed ysician and burial - transit	edical Examiner	events resulting in death) Last Due to (or as a consequence of): d. AMENDED						
	Σl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnant 1 Live birth 4 Pregnant at time of death	2 Fet	8 10/4/1 ral death 3 [ner (Specify)	O TT Ectopic pregna	псу	23d. Date of delivery	Day Year
that the death	by Phy	Part II. Other significant conditions contributing to death but not resu	ilting in the ur	nderlying cause gi	iven in Part I.		bacco use contribute to	
	Completed					24a. Was a autops perform	an 24b. Were au prior to comed? death?	topsy findings available completion of cause of
ician: s certifi rector,	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 EF	R/Outpatient		of Death (Check of Death (Chec		Residence 6 🗸 Other	- Scono
on of V anding Phys ath. r: After thi	tion: To	27. Matural 5 Pending 28a. Date of Injury (Month, Day, Year)	8b. Time of In	njury 28c. Injury	y at Work?		ow injury occurred	
Division Hospital or Attend 24 hours after death. Funeral Director:	Certification	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury · At home determined (Specify)	e, farm, stree	t, factory, office bu	uilding, etc.	28f. Location (S or Town, St	treet and Number or Ru ate)	ral Route Number, City
To the Host within 24 hc To the Fun completely i	Medical (29a. Certifier 1 Certifying Physician: To the best of my knowledge, one 2 Medical Examiner: On the basis of examination and/and manner stated.						
F 3 F 3	Me	29b Signature and title of certifier	_	29c. License O.C.N			29d. Date signed (Moi August 9, 2010	nth, Day, Year)
		Se. Name and address of person who completed cause of death (Item 23 Laron Locke MD. Assistant Medical Examiner	•	Street, Baltim	nore, MD 212	01		
Sta	ate	31. Date filed (Month, Day Year) 33. Registrar's Signature	bar	W				

State of Maryland / Department of Health and Mental Hygiene

Physician /Medical **Examiner**

Funeral Director

with the Maryland 28a-f show the Medical Examiner must be notified at items 23a or filed within 72 hours after "natural", or s 1 and 2 should be filed w f Health and Mental Hygier tem 27 is marked other th

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau **Physician** /Medical

Examiner the burial-transi The law requires that the death certificate be exect Box 68760, P.0. signed by the a Division of Vital Records, certificate Hospital or Attending Physician: this After Director: within 24 hours a

To the Funeral [

Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death Day July 31, 2010 E. Vendemia 5:00 p M 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Montgomery Sunrise of Rockville Rockville If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours Min Cou*ntry)* Virginia 1 □ M XX F Yrs. 15, **1**909 100 Aug. 578-44-0905 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐Yes 2 No Directo Rockville Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 28 Eton Overlook 20850 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White Specify \$ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mildred Ficklin Thomas Echols ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mildred V. Himmelberg/Daughter 28 Eton Overlook, Rockville, MD 20850 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Aug. 5 2010 Washington National Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he art failure. List only one cause on each line. Immediate Cause (Final Chronic Obstructive Pulmonary Disease vears disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Year 5 Other (specify) 1 ∐Yes 2 🕱 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Assisted Living 1 Yes 2 **X**Xo Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 🔀 Natural 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier ical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D27985 August 2, 2010 version, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1201 Seven Locks Road, #111, Rockville, MD 20854 William Silverman, MD 31. Date filed (Month, Day, Year, 22. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

MD

2160

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 | 0 25757 For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Windsor Physician/ Donald 2346 P M Tully 2010 Medical 4a. Facility Name (if not institution, give street and number) ation of Death 4c. County of Death 4b. City, Town, or Locat Cheverly **Examiner** Prince Georges Hospital Prince Georges 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral Days Hours March 1, 1933 1 XM 2 - F Washington, DC 77 Director 217-28-1993 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director Yes 2 No Maryland Hyattsville Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20784 U.S.A. 6708 Stanton Rd. 12. Was Decedent Ever in U.S.
Armed Forces?
1 No 1951If Yes, Give 1954 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: 3 X Widowed 4 □ Divorced Year or Dates. 1954 White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) e 1 and 2 should be filed within 72 F of Health and Mental Hygiene. If item 27 is marked other than "n or other traumatic event, the Medi (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Refrigeration Mechanic Giant Food 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard Windsor Hazel Hutchinson 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 813 Sunny Chapel Rd. Odenton, MD 21113 19a. Informant's Name/Relationship (Type, Print) Margaret Del Collo (Daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham Vet. Cem. Aug. 5, 2010 Cheltenham, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, MD 20706 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Priysician/ Non Small Cell Lung Cancer Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Month Dav Year Yes 2 No signed by the a d be detached 1 g 🗆 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þv Chronic Obstructive Pulmonary Disease, Hypertension, 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? Hyperlipidemia, Peripheral Artery Disease 24a. Was an autopsy performed? Yes 2 N 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 1 Yes 2 No 1 ☐ Inpatient 2 K ER/Outpatient 3 ☐ DOA Other: |은 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director; After th completed filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signatur 29d. Date signed (Month, Day, Year) N July 30, 2010 D55559 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7525 Greenway Center Dr. Thomas E. Maslen #312 Greenbelt, MD 20770 Month, Day, 32. Registrar's AUG 0 4 2010

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 3. ^{Day} 2010 Physician/ Williams 7:56 A Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Prince George's 4407 West Summer Road Suitland If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funera 1**X**XM 2 □ F Months Days Hours Min. 1271271934 579-44-9741 Washington, DC 75 Director Usual Residence of Decedent 28a-f show 10a. State 10c, City, Town or Location 10d. Inside City Limits Examiner must be notified at be filed within 72 hours after death with the Maryland Director Prince George's 1 🗌 Yes 2 🔀 No Suitland [] Maryland 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? USA items 23a Funeral 20746 4407 Summer Road West Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces?

XX Yes 2 \(\text{No} \) No \(\text{1952} \)

If Yes, Give Black, White, etc. o. 1 Never Married 2 X Married ģ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify. "natural", Completed 3 Widowed 4 Divorced Year or Dates. 1955 other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Building Maintenance 12 years Self - Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Huber Elizabeth Miles Williams Joseph permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Joan Williams / Wife 20746 4407 West Summer Road Suitland, Maryland 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 🗀 Donation 5 🗀 Other (Specify) Resurrection Cemetery 08/06/2010 Clinton, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home PA 21. Signature Juneral Service Licensee 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition Physician, 200 Medical resulting in death) to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examin burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last 0000 and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law 24 hours after death.
Funeral Director: After this certificate has! autopsy perform Yes 2 No 2. No 1 🗌 Yes the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be Hospita Other: မ 1 Yes 2 **N**No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending 1 🗌 Yes 2 🗆 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

210+1 State Registrar

DHMH 17 Rev 7/2009

29b. Signature

30. Name and ac

AUG 0

John/∦anDam

4 2010

3508 Old Silver Hill Rd. Suitland, Maryland

who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Certifying Nurse Practic

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Reg. NZ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Walder N. und re-2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** USA Baltimor y of meryland medical c 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign . Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** Days 1 M 2 M F Months Hours Min. (Month, Day, Year) 45 143562 8 MD **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho ral", or items 23a or 28a-f sho Examiner must be notified at Director MD DORCHESTER 1 ¥Yes 2 ☐ No HULLOCK 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21643 Funeral USA 105 ANDILEWS Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ➤ No 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates KIHITT Specify: Completed 3 ₩Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ed other than " event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Sewing FACTORY PENMO Seamstress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Margaret Saunders ည Medford Stoker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $2683\ Wild\ Turkey\ Road$, Seaford , $DE\ 19973$ Gene A. Walden, Sr./Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Unity-Washington Cem. 08/04/10 20a. Method of Disposition 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State Hurlock, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, P.A. 21. Signature of Funeral Service Licensee Main St., Federalsburg, MD 21632 216 N. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ hileka Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Cther (specify) in the past 12 month Month Year Dav Pregnant at time of death ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 ☑No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 1 ☐ Yes 2 ☐ No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner eath 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation within 24 hours after deat

To the Funeral Director:
completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year)

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

AUG 02

2

32

5

egistrar's Signature

31

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last 2. Date of Death Physician/ Barbara Month Medical 4a. Facility Name (if not institution, give street a **Examiner** Town, or Location of Death Maryan Baltimore 8. Date of Birth
(Month, Day, Year)
Dec. 23, 1943 **Funeral** Birthplace (State or Foreign Country) 218-40-7445 1 □ M 2 🕅 F Months 66 Director MD Usual Residence of Decedent 28a-f show 10a. State 10b. County r than "natural", or items 23a or 28a-f sho the Mediral Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Caroline Preston 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 22730 Havercamp Road 21655 United States 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 M Married Yes 2 X No Yes, Give þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) within 72 permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Board of Education of Elementary/Seconday (0-12) 1 1 College (1-4 or 5+) Instructor/Sch. Bus Driv Caroline County Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ James Milton Watts Helen Haddock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald L. Willoughby/Spouse 22730 Havercamp Road, Preston, MD 21655 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cometery, crematory or other place)
Junior Order Cemetery, 07/28/10 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Preston, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, 21. Signature of Funeral Service Licensee whall 216 N. Main St., Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition Ph sician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last attending physician Physician/Medical P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery t 12 months? Ectopic pregnancy detached for in the past 12 Day 5 Other (specify) Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be Division of Vital Records, Hospital or Attending Physician: The law requires 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? certificate director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral or 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Acciden 5 Pending iniury work? Accident Investigation 2 🔲 No Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical Excertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. မှ 29d. Date signed (Month, Day, Year) 00586 2010 3a) (Type, Print) St. Baltimore, MD 2120 Sou

1 DHMH 17 Rev 7/2009

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			. For	State of M	arylan	d / Depa	rtment of	Health	and M	ental Hy	giene	010	25761
		_1	State Registrar			Cer	tificate of	Death			Reg. No.	010	23101
Physic	cian	_	Decedent's Name (First, Middle, La	. 1						2. Date of De Month	ath Day	Year	3. Time of Death O451 PM
Me	dica	ı	4a. Facility Name (if not institution, give	re street and number)			4b, City, Town,	or Location	of Death	07	4c. C	acio ounty of Death	1
Exan	nine	-	Onines ty of 1 5. Social Security Number 6.		Mes	ارس د۲۱		wor			10.0	ounty of Boun	
Funer		- 1	5. Social Security Number 6. 218–24–6033	Sex 7. Ag 1 M 2 X F	e (In yrs. la 78	ist birthday) Yrs.	If Under 1 Yea Months Days	r If Under	r 24 Hrs.	8. Date of Bir (Month, Da Dec 16	h y,1 ^Y ear)	9. Birth Cou	place (State or Foreign ntry) y Land
		ļ	Usual Residence of Decedent						<u> </u>	JEC 10	1931	TIGI.	
ryland -f sho led at		뜅ㅣ	10a. State 10b. County			y, Town or Loc							10d. Inside City Limits 1 Yes 2 □ No
he Ma or 28a			Maryland Caroling 10e. Street and Number	ne	G	reensb	10f. Zip Code		-		10g. Citize	en of What Cou	
with the s 23a of ust be	ľ	Funeral	702 Harold Street	:	21639						US	A	
11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify C									igin? (Spec n, Puerto F	cify Yes or No- Rican, etc.)	14	. Race - Ameri Black, White,	
036 s after ral", o	To 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Year or Dates.									pecify: Bla	ick		
5-0 2 hour "natu		Completed	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business (Specify only highest grade completed) (Give kind of work done during most of working										ndustry
121 ithin 7 ene. r than		<u> </u>	Elementary/Seconday (0-12) College (1-4 or 5+) life. DO NOT use retired) production canning										
filed w al Hygi s other vent, i		B B	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)										
ylai	ď	۱٩	MICHAEL MINES										
Man 2 shor th and 27 is n traum			19a. Informant's Name/Relationship Beverly Warner/			1							Code) , MD 21639
1 and of Hea			20a. Method of Disposition			lace of Dispos	sition (Name of patory or other pi			ate		ation - City or T	
imc. Page ment cant tant: If			1 X Surial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec			kers C	emetery						o, Maryland
Baltimore, Maryland 21215-0036 permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Headt and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 29a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	ouce.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility PO Box 160; Greensbor Fleegle and Helfenbein Funeral Home,										
			23a. Part 1. Enter the disease, or con shock, or heart failure. List only	mplications that caused one cause on each line	d the deat e.	h. Do not ente	r the mode of dy	ring, such as	cardiac o	respiratory ar	rest,		Approximate Interval Between Onset and Death
Physicia Medic	_	١	Immediate Cause (Final disease or condition resulting in death)	a. Due to (or	-	tence of:						- 4	Criset and Death
Examin	er			Due to (or as	a consequ	ierioe oij.							
D #		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequ	ience of):							
recuted and and	- ,	Exan	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequ	ience of):							
Box 68760 death certificate be executed ne attending physician and ed for use as the burial-transi		<u> </u>		■ d									
P.O. Box 68760 that the death certificate kended by the attending physic electored for use as the less than 100		Pnysician/Med	IF FEMALE:	00-16	-f								
OX 6 ath ce attend for us	ŀ	clan	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a	2 Feta	ldeath 3 🗆	Ectopic pregnal Other (specify)	ncy			23	d. Date of deli Month	very Day Year
O. B the de by the tached		l ys	g 🗌 Unknown	g 🗌 Unknown									
ords, P.O. Be requires that the despensioned by the should be detached	J.	중	Part II. Other significant conditions	contributing to death t	out not res	uiting in the u	nderlying cause	given in Part	I I.	23e. Did t		/	the cause of death?
ord: v requi s been shoulk		Completed								24a. Was		24b. Were aut	opsy findings available
/ital Reco sician: The law s certificate has b lirector, page 2 s		mo,								auto perfo	rmed?	death?	ompletion of cause of
ital Re sician: The certificate rector, pag	1	e l	25. Was case referred to medical examiner?	Hospital:				Place of Dea	ath <i>(Check</i>				
of Vi Physi rthis or	ŀ	<u>o</u>	1 Yes 2 No 27. Manner of Death	1 M Inpati	iry	ER/Outpatien 28b. Time of	t 3 🗆 DOA			ne 5 🗆 Resi		Other (Special	5/)
on or			1 Natural 5 Pending 2 Accident Investigati		y, Year)	injury	wo	ork? □ Yes 2 □					
Division of Vital Records, tal or Attending Physician: The law requires rs after death. al Director: After this certificate has been signed in by the funeral director, page 2 should b		Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine				et, factory, office	Э	2	28f. Location (S City or Tov		Number or Rura	al Route Number,
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach		Medical	(Check 2 Medical Example (Check 2 Medical Example)		xamination	and/or invest	igation, in my opi	nion, death o	occurred at	the time, date a	ind place, a	nd due to the c	ause(s) and manner stated.
To the within To the comple			only one) 3 ☐ Certifying No. 29b. Signature and title of certifier	urse Practioner: To the	nest of m	r knowledge, c	29c. Licer	se number	: <u></u>			signed (Month,	
			Legar Ja	& M.D.			18-	1817	833	6	71	23/2	010
			30. Name and address of person who	completed cause of d	leath (Item	, , , , ,		- B	0.1		110	212	1
	State		31. Date filed (Month, Day, Year)	37 Registr	ar's Signa	Gree de	Me ST	, 0	WY,V	never	MD	out of (1
Regis			JUL 39 2	010	0/	a. March							

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 Wenzel August 2:00 AM Rosemarie Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Howard 3675 Mt. Ellicott City Ida Drive 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country) _ Month, Day, YApril 21 Months Days Min 1 □ M 2**X** F Director 213-28-4897 79 1931 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Ellicott City Howard 10e, Street and Number ö 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 3675 Mt. Ida Drive 21043 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ò 1 Never Married 2 Married ð Maryland 21215-0036 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. "natural", Specify: 3X Widowed 4 ☐ Divorced Completed White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 8 Day Care Provider Day Care injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of ည Donald McDermott Rose Ewing permit. Page 1 and 2 should Department of Health and Me Important: If item 27 is mar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosemarie Simon/daughter P.O. Box 843 Annapolis, Maryland 21404 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🛣 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 8/3/2010 Woodbine, Maryland Sign of Funeral Service Lice Coling Hones Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, M any Thomas M00957 MD23a. Part the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician 10ncu disease or condition mon Medical resulting in death) Due to (or as a consequence m) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): sician and burial-trans Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 as the l IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ been signed by the atte should be detached for Month Pregnant at time of death 9 Unknown 9 Unknow P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autonsv perform death? 1 ☐ Yes 2 XNo Yes 2 Division of Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ပု 1 🗌 Inpatient 2 🗌 ER/Outpatient 3 DOA this the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔼 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fur 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) the Hospital Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 0 mmo 2010 Long 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sui namners MD

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year) AUG 03

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **29**^{Day} Physician/ JULY 2010° 7:29 PM ALBERT LEROY WEBER Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death STEVENSVILLE **OUEEN ANNE'S** 416 BAY CITY ROAD 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 F 78 Months Days Hours Min. AUG 1 Day, 1931 MARYLAND Director 214-28-6323 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 🗌 Yes 🛣 No MARYLAND QUEEN ANNE'S STEVENSVILLE 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral or items 23a 416 BAY CITY ROAD 21666 UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Widowed 4 Divorced Specify: WHITE 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) MINISTER **MINISTRY** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I important: If item 27 is marked o any injury or other traumatic evenores. 0 ARTHUR WEBER LOUISE DAVIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KATHY TROTTER/DAUGHTER 416 BAY CITY ROAD, STEVENSVILLE, MARYLAND, 21666 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State CHESAPEARE CREMATION 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE, MARYLAND CENTER, LLC 21. Signature of Funeral Service License FELLOWS HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND, 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest, Approximate Immediate Cause (Final Physician DIVATO week disease or condition Medical resulting in death) Examiner ears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner ears been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or linjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗆 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manger of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Investigation
6 Could not be 1 ☐ Yes 2 ☐ No ☐ Accider
☐ Suicide Accident within 24 hours after death To the Funeral Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signatur 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person w

AUG - 2

Nargaret

31. Date filed (Month, Day, Year)

o completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Malaro

55/27

202 Coursevall Drive Suite

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25764 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death 2010 2010 Month JULY WILLIAMS 6:18 PM BILLY 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Year) 1937 1 XM 2 F Months Hours Min Yrs Virginia Aug. 224-46-0145 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 🗆 Yes 2 🛣 No Virginia Lancaster White Stone 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 544 Brightwaters Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Xyes 2 No 1957 Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: 3 ▼ Widowed 4 □ Divorced White 1980 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) US Air Force 5+ Flight Mechanic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elise Layne Nathaniel Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 211 Glade Blvd., Walkersville, MD 21793 Teresa Monacelli / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🔲 Burial 2 🛣 Cremation 3 🗀 Removal from State 8/3/2010 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory Stauffer Funeral Home 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Day disease or condition resulting in death) Due to (or as a consumence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death g
Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Cardia Myopath 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 Yes 2 No

Physician/ **Medical Examiner** Examine

Physician/

Medical

Director

Funeral

þ

Completed

Be

မ

Examiner

Funeral

Director

28a-f show

items 23a or 28a-f s per must be notified

Examiner

ò

al Hygiene.

of Health and Mental Hygie If item 27 is marked other or other traumatic event, the

permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve

with the Maryland

death \

within 72 hours after ier than "natural", the Medical Exan

Baltimore, Maryland 21215-0036

or Attending Physician: The law requires that the death certificate be executed burial-transit physician s the burial use as 1 attending for been signed by the a should be detached f page 2 s has certificate funeral completed filled in by the

Physician/Medical

þ

Completed

Certificate: To

Medical

25. Be

Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this

12 FIUA State Registrar

25. Was case referred to medical		26. Place of Death (Che	ck only one)							
examiner? 1 Yes 2 No	lospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)									
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		28c. Injury at work? M 1 1 Yes 2 No	28d. Describe how injury occurred							
3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined		eet, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
(Check 2 Medical Exam	iner: On the basis of examination and/or invest	tigation, in my opinion, death occurred	and due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s) and manner sta ace, and due to the cause(s) and manner as stated.							

ated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

MAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.

5/6/0 16 Tolino 21702

MO

AUR Suite Frederick

31. Date filed (Month, Day, Year) 32. Registrar's Signature arks AUG 0 Brasand.

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year Mary Jane Wells /Medical July 30 2010 11:25 P M 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Mallard Bay Care Center Cambridge Dorchester 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1 □ M 2 🖾 F Months Days Hours Director 213-76-6449 87 Maryland 11,1923 Apr. Usual Residence of Decedent 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits Director 1X Yes 2 □ No Maryland Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with innent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or i 520 Glenburn Avenue 21613 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married þ 1 ☐ Yes 2 🕅 No Specify 3 X Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Lauck Susie Ann Kimmey 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roy R. Wells/Son Department of Health Important: If item 27 any injury or other to other to P. O. Box 313, Secretary, Maryland 21664 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5 3 Removal from State 5 Other (Specify) East New Market Cem. 8/5/2010 East New Market, MD Zeller Funeral Home, P. O. Box 207 21. Signature of Funeral Service Ligense 106 Main Street, East New Market, MD 21631 Enter the disease, or complications that of used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only on cause or each line. art L Enter the disease, or compile authors a k, or heart failure. List only on cause. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** dementi 2 heimers 5 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Find Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 9 Unknowf Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 ☐Yes 2 ☐ No 1 □Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Director: After that in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐Yes 2 ☐ No 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide To the Hospital or within 24 hours aff To the Funeral Di Completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

Maryland 21215-0036

Baltimore,

P.O. Box 68760

Division of Vital Records.

State Registrar 29b. Signature and title of certifier

Name and a dress of person who completed cause of death (Item 23a) (Type, Print)

100 3. Registrar's Signature 29c. License number

Branche St, Cambridge MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Elsie S. Winebrener 2010 August 2050 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Citizens Care and Rehabilitation Center Frederick Frederick If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 🕱 F June 26, 214-10-5609 102 Months Days Hours Director Washington DC Usual Residence of Decedent show Hygiene. other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location Director 10d. Inside City Limits Maryland Frederick Frederick 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1900 Rosemont Avenue 21702 Frederick within 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗷 No Specify: 3 X Widowed 4 Divorced Specify. White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Accountant Construction permit. Page 1 and 2 should be filed wit.
Department of Health and Mental Hygie.
Important: If item 27 is marked other:
any injury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Leo H. Sommerfield Carline Steiner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clay Martz/ Attorney 117 West Patrick Street, Frederick, Maryland 21701 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Mount Olivet Cemetery August 10, 2010 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funefall Keeney & Bastord P.A. Funeral Home M01433 106 East Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on worth line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): g physician and as the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown ò Pregnant at time of death Day 5 Other (specify) been signed by the should be detached To the Hospital or Attending Physician: The law requires that the Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 🗌 Yes 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available page 2 s has autopsy prior to completion of cause of death? certificate Yes 2 **Division of Vital** 24 hours after death.
Funeral Director: After this certificeted filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes ျှ Other 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of ath 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one)

State Registrar 29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

and address of person who

Print'

ted cause of death (Item 23a) (Type,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Samuel Jacob Winters, Sr. 6:35 P /Medical August 7 2010 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington Williamsport Homewood of Williamsport 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Months Days Hours 215-05-7284 Director 25, 101 1909 Maryland July Usual Residence of Decedent 10a. State 28a-f show 10b. County 10c. City. Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☑ No Maryland Washington Smithsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 22008 Beaverbrook Drive 21783 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married ò à 1 ☐ Yes 2 ☐ No Specify: Specify: 3 N Widowed 4 Divorced White "natural" Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) wental Hygiene. 127 is marked other than "retraumatic event". Elementary/Secondary (0-12) College (1-4or 5+) 10 Farmer Dairu 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ardie Walter Winters, Sr. Shirdie Elizabeth Honodel ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health 22307 Republican Ave. Smithsburg, Maryland 21783 (Daughter) Dorothy M. Gutshall item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other pi Cavetown Church Date 20c. Location - City or Town, State August permit. Page Department o Important: If any Injury or once. = 5 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Cavetown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2010 Cemeteru Signature of Funeral Service Licensee MO1414 22. Name and Address of Facility J.L. Davis Funeral Home 100 12525 Bradbury Ave. Smithsburg, Maryland 21783 20a: Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Thoke disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease of injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-tran Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗌 Ectopic pregnancy Month Day 5 Other (specify) signed by the a ☐Yes 2 ☐No 9 Unknown 9 Unknown putions contributing to death but not esulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 1 □Yes 2 No 1 ☐ Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one)

The law requires that the death certificate be executed P.O. Box 68760, of Vital Records, To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director, p Division

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Registrar DHMH 17 Rev 1/2001

State

29b. Sia

31. Date filed (Month, Day,

who completed cause of de TOUR

7

AUG 172010

and

Registrars

Medican Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

290 License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		aryland		artment of F rtificate of L		Mental Hy	giene Reg. No.	010	25768
	Physicia Media		1. Decedent's Name (First, Middle, I	_ast) M Y RON	WR	IGHT			2. Date of De Month Aug	ath 2 Day	2010 Year	3. Time of Death
, and the same	Examir		4a. Facility Name (if not institution, g	ive street and number)	,,,,,,		4b. City, Town, or		h	1	County of Death	7.00 1
and the	Funeral		69 Aberdeen 5. Social Security Number 6	. Sex 7. Aq	e (In yrs. las	st birthday)	If Under 1 Year	berdee	100.00	th		ford hplace (State or Foreign
	Director		128-18-5374	1∭ M 2 □ F	81	Yrs.	Months Days	Hours Min	8. Date of Bir (Month, Da	1928	8 Pen	intry) insylvania
	and show dat	٥	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	ocation					10d. Inside City Limits
	Maryl 28a-f lotifie	Director		rford			A	berdee	n			1 🗆 Yes 2 💢 No
	ith the 23a or st be n	ralD	10e. Street and Number 69 Aberdee	n Arronia			10f. Zip Code	.001		_	en of What Cou	-
	tems ter mus	Funeral	11. Marital Status	12. Was Decedent I	er in U.S.	13.	Was Decedent of Hi If Yes, specify Cuba		pecify Yes or No-		11. U.C.C. 4. Race - Ameri	States ican Indian,
36	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 🛣 Marrie 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give			If Yes, specify Cuba 1 ☐ Yes 2 ☐ No		o Rican, etc.)		Black, White	, etc.
2-0	hours hatur dical B	olete	15. Decedent's (Specify only highest	Year or Dates.	19	16a. Dece	dent's Usual Occupa	ation		16b. Kind	d of Business II	hite ndustry
21215-0036	within 7% yelene.	Completed	Elementary/Seconday (0-12)	College (1-4 or 5	j+)	life. D	kind of work done do NOT use retired) CUPITY	Guard	rking	E7.	ectric	Power
<u>م</u> 2	filed wall Hygi	Be	17. Father's Name (First, Middle, Las	t)		~	JOAT 70%		me (First, Middle,			1000
Maryland	should be file and Mental I is marked o raumatic eve	욘	Lawren			Wrigh		Syl				known)
⊠	2 shorth and the and 27 is not traum		19a. Informant's Name/Relationship June Dalton	(Type, Print) (Daughte	7		ng Address (Street a		ral Route Numbe Aberd			Code) 21001
ore,	of Hea of Hea fitem rothe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3		20b. Pla	ace of Dispo	osition (Name of matory or other place		pate 6,		ation - City or T	
Baltimore,	it. Page rtment rtant: I njury o		4 Donation 5 Other (Spe	cify) J		ttsv:	ille Cem	. 2	010			lle, MD.
Ba	permit. Page 1 and 2 si Department of Health a Important: If item 27 is any injury or other tra once.		21. Signature of Funeral dervice Life	on hurt	سللف	210	Name and Address		.G. Kur arretts			Funeral ryland
			23a. Part 1. Enter the disease, or co shock, or heart failure. List only	one cause on each line	1			g, such as cardiad	or respiratory arr	est,		Approximate Interval Between
e	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Chro	nic C	DOSTR	heart	Lulmon	ary dis	CAS <		Onset and Death
	Examiner	J.	Sequentially list conditions,	b. Com	gest	ive	heart -	Failu	re			
٥.	ted I	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a	a čonseque	nce of):						
1/2	icate be executed physician and s the burlal-transi	al Ex	that initiated events resulting in death) Last	Due to (or as a	conseque	nce of):			-			
760	cate be physic s the bi	/ledical		d								
ထ္ထ	death certifi ne attending ed for use a	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnance	cy death 3 [Ectopic pregnancy	,		23	3d. Date of deliv	/ery
		Physician/N	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at 9 Unknown			Other (specify)			:	Month	Day Year
, P.O	requires that the been signed by the should be detach	þ	Part II. Other significant conditions	contributing to death be	ut not result	ting in the	nderlying cause give	en in Part I.				the cause of death?
ords	requir been s should	letec	11/10110	10110	v Ceco	14 01	0000		1 🗆 \			obably 4 Unknown
Division of Vital Records,	The law ate has bage 2 s	Completed							autop	sy med?		ompletion of cause of
E .	ician; certific ector,	Be	25. Was case referred to medical examiner?	Hospital:				ce of Death (Chec		2 140	1 🗆 163	2 - 110
01	g Phys er this eral dir	e: 10	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 Inpatie	y 2	8b. Time of	t 3 DOA Other	4 ☐ Nursing H	ome 5 Resid			y)
0	tendin leath. or: Aft the fun	Certificate:	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigat 3 ☐ Suicide 6 ☐ Could not		Year)	injury	M 1 □ 1	/es 2 □ No		,,		
SINIC	after of after of Direct of in by		4 Homicide determine		ry - At hom . (Spec <i>ify)</i>	e, farm, stre	eet, factory, office		28f. Location (Si City or Town		lumber or Rura	l Route Number,
-	To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate he completed filled in by the funeral director, page	Medical	(Check 2 in Medical Exa	ysician: To the best of r niner: On the basis of ex	amination a	nd/or invest	idation. In my opinior	n, death occurred a	at the time, date ar	nd place ar	nd due to the ca	use(s) and manner stated
:	To the within 2 To the comple		only one) 3 Certifying Nu 29b. Signature and title of certifier	rse Practioner: To the b	est of my k	nowledge, o	eath occurred at the 29c. License	time, date and pla	ce, and due to the	cause(s) ar	nd manner as st	tated.
D	. ٧		Herryo	L'Her	/_			6547			8/	3/2010
	321		30. Name and address of person who	completed cause of de	atil (Item 2	3a) (Type, P — 00	rint) S. Wull	in Ave	. HAVK	PD	e Grace	21078
	Stat Registra	_	31. Date filed (Month, Day, Year) AUG 1 7 2010	32. Registra	Signatu	ale	,					

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 within 24 hours after de

To the Funeral Directo

completed filled in by th

3altimore, Maryland 21215-0036

State Registrar (Check only one)

1126 apalct. 31. Date filed (Month, Day, Year)

tate in Smith CRIP

Name and address of person who completed cause of death (Item 23a) (Type, Print)

312010

tagerstown, MD 21740

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #11 Per INF G912 2/18/2011 JH
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 5:00 a^M July 26, 2010 0. Leona Weaver 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Kensington Nursing & Rehab. Center Montgomery Kensington 8. Date of Birth (Month, Day, Year April 30, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)

Iowa 5. Social Security Number 7. Age (In yrs. last birthday) Year) 1911 Months Hours 1 □ M 2 F Days 99 480-07-1360 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No Maryland Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3003 Jennings Road 20895 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 22 Married Specify: White 1 ☐Yes 2 XNo Specify: 3XXVidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerical Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Augustine Otto Louise Kronenberg 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14704 Bayview Drive, Woodbridge, VA 22191 Martha E. Weaver/Daughter-in-law 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State July 31 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2010 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility in S Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure Due to (or as a consequence of): Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Year Dav 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Physician /Medical **Examiner**

Physician

/Medical

Examiner

10a. State

Director

Funeral

þ

Completed

Be

မ

Funeral

Director

ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

f Health and Mental Hygiene. item 27 is marked other than other traumatic event, the M

permit. Pages 1
Department of H
Important: If ite
any Injury or ot

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examine burial-transit physician Physician/Medical as the attending p cate has been signed by the a page 2 should be detached to Completed by certificate funeral director, Be After this Certification: To To the Hospital or Attendin.
within 24 hours after death.
To the Funeral Director: Aft
completely filled in by the fur

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

9 ☐ Unknown	9 Li Onknown
Part II. Other significant condi-	tions contributing to death but not resulting in the underlying cause given in Part I.
Dementia	

1 ☐Yes 2 No 26. Place of Death (Check only one) Other: 4x Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only one)	2 Medical		On the and ma	
29b. Signature and	title of certifier	Carl	ezp	0

determined

of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) stated. 29d. Date signed (Month, Day, Year) 29c. License number

D0064624

July 26, 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunner Walk Dr. Gaitherburg, MD 20878 SANDEEP 743 SHARMA

31. Date filed (Month, Day, Year) State

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☐ No

27. Manner of Death

1 XNatural

2 Accident

4 ☐ Homicide

3 ☐ Suicide

ca

30



Registrar

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 201°0 31 8:14 Elmer R. Williams p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Somerford Assisted Living Columbia Howard Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 Å M 2 □ F Days Min. Months Hours 0871371939 70 228-52-5866 Yrs Director VA Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director 1 Yes 2 No FLSt. Johns St. Augustine 0. 10e. Street and Numbe 10g. Citizen of What Country? Funeral 23a 608 Mediterranean Way 32080 United States d Mental Hygiene. marked other than "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces' Black, White, etc. 1 Never Married 2X Married ğ 1 X Yes 2 ☐ No 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Salesman Paper Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be file of Health and Mental F item 27 is marked of 2 Pete Williams Irene Pridemore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathryn Williams - wife 608 Mediterranean Way St. Augustine, FL 32080 or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or otl cemetery, crematory or other place Burial 2 Cremation 3 Removal from State 08/04/2010 | Marriottsville, MD Crest Lawn Mem. 4 Donation 5 Other (Specify) permit. Signature of Funeral Service Licensee $10010\overline{44}$ 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ prostate disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last the burial attending physician for use as the burial Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery for in the past 12 months? Month Day Year signed by the a Yes 2 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 → Yoo 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No The 1 Yes Hospital or Attending Physician: completed filled in by the funeral director, B B 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: S CAM S CHOY & 2 No 1 Yes မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Special Control of the Control After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No injury 1 XNatural 5 Pending s after death. 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 1 👺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 _ To the within 2 To the F only one 29b. Signature and title of certifie 29c. License number 1.40 DO57436 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

54

Box 68760

P.O.

Records,

Division of Vital

DHMH 17 Rev 7/2009

33- 2

Greene St.

Mh

Registrar's Signature

teather Donance

2010

Bouthon creinio 21201.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2010 Physician/ Aug. 1, 8:36 a M Huan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Yo Aug 21, Birthplace (State or Foreign Country) 5. Social Security Number Funeral Year) 19<u>53</u> Days Months Hours 1 XM 2 F Aug. 218-31-4658 Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location 10a. State Director 1 Yes 2 No Maryland Montgomery Rockville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 20853 USA 12630 Viers Mill Road, #207 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Bace - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married \$ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes Give Completed 3x Widowed 4 ☐ Divorced Asian 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Waiter Food Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wo Q. Ye Xue Fang Lin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10012 Renfrew Road, Silver Spring, MD 20901 19a. Informant's Name/Relationship (Type, Print) Cai Zhen Li/Niece 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite any injury or ot cemetery, crematory or other place)

Gate of Heaven Cemetery Aŭĝ103 1 X Burial 2 Cremation 3 Removal from State Silver Spring, Maryland 4 Donation 5 Other (Specify) 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, Signature of Funeral Service Licenses MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Pnysician Medical Examiner attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760

Completed by Physician/Medical Examiner

within 24 hours after death.

To the Funeral Director; After this certifica completed filled in by the funeral director, I

æ

မ

Certificate:

Medical

examiner?
1 Yes 2 No

5 Pending

Investigation 6 Could not be

27. Manner of Death

X Natural

4 Homicide

29a. Certifier

(Check

only one)

Signature and title of certifier

31. Date filed (Month, Day, Year)

Name and address of person who complet

AUG 03 2010

Accident Suicide

Immediate Cause (Final disease or condition	Myocardial Infarction			Onset and Death						
resulting in death) Sequentially list conditions,	Due to (or as a consequence of): Hypertension	Hypertension								
if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to (or as a consequence of):	c. Due to (or as a consequence of):								
resulting in death) Last	d									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown		23d. Date of d Month	elivery Day Year						
Part II. Other significant conditions	s contributing to death but not resulting in the underlying cause given in Part I.			to the cause of death? Probably 4 xUnknow						
		24a. Was an autopsy performed? 1 □ Yes 2 □	prior to death?	utopsy findings available completion of cause of \square No						
25. Was case referred to medical	26. Place of Death (Check	k only one)								

28c. Injury at work?

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

1 🗆 Yes 2 🗆 No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D64008

29c. License number

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

1500 Forest Glen Road, Silver Spring, MD 20910

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year) August 1, 2010

State

Registrar

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

cause of death (Item 23a) (Type, Print)

Eddie Fernandez,

2. Registrar's Signature

28b. Time of

28a. Date of injury (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** William F. Allison 2,2010 4:28P <u> August 1</u> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 326 Five Farms Drive Stevensville Oueens Anne If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Months Min. 97 Days 1 X M 2 □ F Director 214-01-8213 October 4,1912 Pennsylvania Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Ex. reiner must be notified at Md. Stevensville 1 □Yes Z No Director Queens Anne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 326 Five Farms Drive 21666 USA Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
Int: If feat 27 Is marked other than "natural", or items 23s into other traumatic event, the Worle Exercite mans in yor other transmatic event, the Worle I Exercite must by Funeral 12. Was Decedent Ever in U.S.
Atmed Forces?
1 2 Yes 2 □ No
If Yes, Give
Year or Dates: 1943–1945 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No White Specify Specify: 3√□ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Wholesale Men's Elementary/Secondary (0-12) 10th College (1-4or 5+) Credit Manager Clothing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Evelyn Hibner Robert Small ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Albert Diederichs Son 326 Five Farms Drive Stevensville, Md. 21666 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: if ite
any injury or oti 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Bayview 8-16-2010 Balto. Md. 21224 21. Signature of Funeral Service Lice 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Road Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Onset and Death

3 Months Immediate Cause (Final **Physician** CANCER ung disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-tran Due to (or as a consequence of): P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) ed by the a signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate Division of Vital 1 ☐ Yes 2 ☐ No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1X Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 24 hours after death e Funeral Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 THomicide filled in 29a. Certifier 1 🐹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D39887

Registrar

Smith David AUG 182010

Name and address of person who comp

MD-8221 Teal Drive-Suite 301 Easton. MD 2169 32. Registrar's Signature

08 3 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #41 State of Maryland Begartment of Health and Mental Hygiene 25774 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Anna Marie Aumiller Mugust D**4**y1 20°10 4:53 P_{M} Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 8800 Walther Blvd Parkville If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 1 M 2 X F Aug Month, Pay, Year 25 Maryrand Director 84 219**-**16-8781 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director "natural", or items 23a or 28a-f s edical Examiner must be notified MDBaltimore 1 🗌 Yes 2 🎦 No Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8800 Walther Blvd #1504 21234 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: white 3 X Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene.

It is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) medical secretary healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Amelia Presinger John Schwalenberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21214 4632 Walther Avenue; Baltimore, Maryland 21214 permit. Page 1 and 2 sh.
Department of Health ar
Important: If item 27 is
any injury or other trau Donna Garvey - daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board Signal of Luner Service License Director 655 W. Baltimore Street; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Seuse (Final Approximate Interval Between Onset and Death Physician/ disease or condition ^Medical resulting in death) Due to (or as a consequence of): Examiner Pancytopenia Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events -Cell Lymphoma. advanced and burial-tran Due to (or as a consequence of resulting in death) Last the attending physician Physician/Medical that the death certificate be IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? detached for Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Vital Be 26. Place of Death (Check only one) 2**X** No Other: ဂ္ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) of 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 Tes 2 No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi 29c, License number 29d. Date signed (Month, Day, Year) P171944 chaf m-30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

AUG 17201

8/11/2010 @ 450pm #

Anna

8800 Walther Blud, Parkville MD 21234

32. Registrar's Signature

Michealle Harrison CRM, MIN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. NZ U U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 12:50TM Physician SON 2010 Danie Husust /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days Hours Min 1 X M 2 □ F Yrs Director <u> 217-23-5087</u> 21 2-11-1989 M Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director MD Baltimore Owings Mills 10f. Zip-Code 10g. Citizen of What Country 10e. Street and Number ь 23a 222 Mid Pines Court, Apt. 3D 21117 Funeral USA items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 X Never Married 2 ☐ Married 1 ☐ Yes 25 If Yes, Give Year or Dates: 2X No Baltimore, Maryland 21215-0036 Ь 1 Yes 2 No Specify Specify: þ African-American 3 Widowed 4 Divorced natural" Completed 16a. Decedent's Usual Occupation n/a (Give kind of work done during most of working er than "natur, the Medical F 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Health and Mental Hygiene. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Larry Anderson Veronica Martin မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important; If item 27 is any injury or other tra once. 9531 Painted Tree Drive, Randallstown, MD 21133 Veronica Martin/Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 8-23-2010 Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 Part 1 there the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest show or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic Dac ancer Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Brain herniatar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy Day in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) detached for 1 Yes 2 9 Unknown 2 🗌 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 1 ☐ Yes 2 ☐ No 2 **X**No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 | Inpatient Other: 1 ☐ Yes 2 X No 4 🗌 Nursing Home 2 ER/Outpatient 3 DOA 6 Other (Specify) 5 Residence ဂ္ 24 hours after death.
Funeral Director; After this letely filled in by the funeral. 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 Natural 1 🗌 Yes 2 🗌 No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 ho

To the Fune

completely (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES-000 Vg15+ 15 2010

Registrar

State

600 North Wolfe St, Baltimore, MD, 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

/ama

31. Date filed (Month, Day, Year)

4 lubari

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-25776 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month August Sterling Fugene Alston Jr. 2010 4:17 p_{\bullet}^{M} Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Towson
 If Under 1 Year
 If Under 24 Hrs.
 8. Date of Birth

 Months
 Days
 Hours
 Min.
 (Month, Day, Year)

 8-14-195
 6. Sex_ 1 X M 2 □ F Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 212-58-7433 Director 58 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location **Funeral Director** 1√2 Yes 2 □ No MD Baltimore n/a 10e. Street and Number 10g. Citizen of What Country? 3834 Derby Manor Drive 21215 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 ANo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: African-American 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Honeywell Corp Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sterling E. Alston Sr. Mable Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Alston/Wife Belleville Avenue, Balto. MD 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 8-20-2010 Woodlawn, MD Woodlawn Cemetery Donation 5 Other (Specify) 22. Name and Address of Facility Wile Funeral Home P.A. of Palto. O. 21. Signature of Funeral Service Licensee 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1) Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Enter the disease, or complications that caused the teath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between and pulph Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): ending physician and use as the burial-transit to the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of s certificate has the lirector, page 2 s autopsy perform death? Yes 25. Was case referred to medical Medical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 Yes Other: 4 Nursing Home 5 Residence 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of De funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural
Accident
Suicide
Homicide 5 Pending 24 hours after death. Funeral Director: Af 1 🗆 Yes 2 🗌 No Investigation 6 Could not be filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated vithin 24 hours to the completed file (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature 29d. Date signed (Month, Day, Year)

Registrar

State

address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

10-06083 Marvin Bonner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2010

		1- For State Registrar	Certificate of Death Reg. No.					
Physici edical Exam			- 0	-	Date of Dea Month	Day Year	3. Time of Death	
· · · · · · · · · · · · ·	mer	4a. Facility Name (if not institution, give street and number)	CR Lab	. City, Town, or Location of D	August 14		0342 hrs	
,		Western Maryland Health System		Cumberland	adri	4c. County of Deat Allegany	n	
Funeral			yrs. last birthday)	If Under 1 Year If Under 24	Hrs. 8. Date of Bi	rth(MM/DD/YYYY) 9. Bi	thplace (State or	
Director		217-89-8811 12M 20F	49 Yrs.	Months Days Hours	Min. Aug	21 19/00 Forei	ountry) ARYLAND	
		Usual Residence of Decedent	1 2		119.0	x1, 1200		
w any		1 non 10	City, Town or Location	1.4			10d. Inside City Limits	
daryland 28a-f show 1 at once,	ğ		vew Carr	* * * * * * * * * * * * * * * * * * * *			1 Yes 2 No	
e Mary or 28a Ted at	Director	10e. Street and Number	1 + 102	10f. Zip Code	1	l0g. Citizen of What Cou	ntry?	
15-0036 filed within 72 hours after death with the Maryland al Hygiene. Hygiene. t, the Medical Examiner must be notified at once		11. Marital Status 12. Was Decedent Eye	rin II S 13 Was I	OUT94 Decedent of Hispanic Origin?	(Specify Vos or No	14 Page Amer	ican Indian, Black,	
eath v item	uneral	1 Never Married 2 Married Armed Forces?	, If Yes	, specify Cuban, Mexican, Pu		White, etc.	/ .	
after d al", on	by Fi	3 Widowed 4 Divorced of Pates	Specify: Bla	ick				
hours		15. Decedent's Education (Specify only highest grade complete		Usual Occupation (Give kind t of working life. DO NOT use	of work done	16b. Kind of Business/	Industry	
5-0036 led within 72 hor Hygiene. other than "nat	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	Labor		, our out	Building		
5-003 iled within Hygiene. I other th	, mo	172 Father's Name (First, Middle_Last)	Lawi		ame (First, Middle,	(1		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be C	Ronald G. Snoulden		Franc	- 17	nek		
2121 hould be fil and Mental F is marked tite event,	To 1	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing A	ddress (Street and Number	or Rural Route Nur	nber, City or Town, State		
nore, MD 2121 ages 1 and 2 should be fi nt of Health and Mental 1 it: If item 27 is marked other traumatic event,		Frances Snoulden - Mother	77443	Riverdale Ru	#103 N	ew Carrolte	n, mo 20784	
or Heal		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	 Place of Disposition crematory or other 		/ Date/	20c. Location - City or	Town, State	
E d a m b		4 Donation 5 Other Specify;	Netro Crem	natory 8	/18/10	Catonsville	MO	
Baltimore, permit. Pages I as Department of He Important: If ite		21. Signature of Funeral Servic Librarisee	CAR	oe and dress of Facility	LOCKAL H	ome P.A.	222	
Physician	-	23a. Fair VE/Iter the disease or complications that caused the	leath. Do not enter the	mode of dving, such as cardia	PHSS BAL	est shock or heart	229 Approximate Interval	
/Medical		failure List only one cause on each line.	ce Head Inj		o or respiratory air	oot, oneon, or nour	Between Onset and Death	
^J Examiner		Immediate Ceuse (Final disease or condition resulting in death) a. Blunt Fore		ury				
		Sequentially list conditions, b						
	ine	if any, leading to immediate Due to (or as a consequence of the Enter Underlying Cause	nce of):					
d d	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequent	nce of):					
760, icate be executed physician and the burial - transil	ä	d.	27 20- 5 -		10.10			
760, ficate be execut g physician and the burial - tra	ledical			er me g908 10	-18-10 vi			
6876 certificat nding physe as the	M/us	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of 1 Live birth	pregnancy 2 Fetal	death 3 Ectopic pre	gnancy	23d. Date of delivery Month	y Day Year	
Box 68 c death certif the attending ed for use as	Physician	1 Vas 3 No 9 Hokeaus 4 Pregnant at time	of death 5 Other	(Specify)		1	1	
the de ched f	Phy	Part II. Other significant conditions contributing to death but	not resulting in the und	erlying cause given in Part I	23e Did to	bacco use contribute to	the cause of death?	
rds, P.O. Box 68 requires that the death certification been signed by the attending hould be detached for use as	é		,	ory, ng outpo given in raich.		2 No 3 Prob		
Division of Vital Records, tal or Attending Physician: The law requirers after deep representations. The tales been simple from the funeral director, page 2 should be the funeral director, page 2 should be	ompleted				24a. Was		topsy findings available	
e law e has ge 2 st	립		· · · · · · · · · · · · · · · · · · ·			med? death?	ompletion of cause of	
Vital Rec ysician: The his certificate director, page	ပိ	25. Was case referred to medical		26.Place of Death (Che	1 Yes	2 No 1 Ye	s 2 No	
Vital Recolnysician: The law this certificate has I director, page 2 st	e e	examiner?	2 ER/Outpatient 3		sing Home 5	Residence 6 Other		
ing Ph After t funeral	밁	27. Manner of Death 28a. Date of Injury	28b. Time of Injur			now injury occurred		
ttendi Heath. Heath.	읉	Natural 5 Pending Fd 8-14-1	0 fd 3:08	am 1 Yes 2 x No	subject	was assaul	ted	
Division spital or Attencours after death neral Director: filled in by the	Certification:	3 Suicide 6 Could not be 28e. Place of Injury -	At home, farm, street, f	actory, office building, etc.	28f. Location (S or Town, S	treet and Number or Ruitate) Arch and	al Route Number, City E. First Sts	
D ospital hours ineral y fille	٥		reet					
Division of Vital To the Hospital or Attending Physician: within 24 hours after the After this certif To the Funeral Director: After this certif completely filled in by the funeral director,	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my known one) Certifying Physician: To the best of my known one) Physician: To the basis of examinating the basis of examinatin						
To To CORT	Med	29b. Signature and title of certifier		29c. License number		29d. Date signed (Mor.		
		Sunto Duthall no		O.C.M.E.		August 14, 2010		
	ŀ	30. Name and address of person who completed cause of death	(Item 23a)	1				
		Pamela E. Southall, MD Assistant Medical I	Examiner 111 F	Penn Street, Baltimore	MD 21201			
St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature (Month, Day, Year)	nature ,					

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Degedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month AUGIUST 05.29 A M 2010 Medical Façility Name (if not institution, give street and number) City, Town, or Location of Death Examiner County of Death TURNIE Runde If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Aug. 1959 **Funeral** 9. Birthplace (State or Foreign Country) Director 51 Yrs. 219-82-1271 Usual Residence of Decedent ortant; If item 27 is mar led other than "natural", or items 23a or 28a-f show injury or other traumatit event, the Medical Examiner must be notified at 10a. State within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 🗌 Yes 2 🙀 No Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 602 Ashington Road 21061 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: White Completed 3 Widowed 41 Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should e filed within 72 Department of Health and Meintal Hygiene. Important: If item 27 is man ed other than "any injury or other transments." Elementary/Seconday (0-12) College (1-4 or 5+) Painter Painting Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Herbert J. Bush Sr. Doris Sabastian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris Bush (mother) 7857 Crilley Road, Glen Burnie, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Aug.Date 2010 20c. Location - City or Town, State cemetery, crematory or other place)
Metro Crematory Inc. 18 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral-S 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 har caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications shock, or heart failure. Dist only one cause Approximate Interval Between Onset and Death Immediate Cause (Final VENTRICULAR FIBRILLATION Ph sician/ disease or condition Medical resulting in death) SEVERAL **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burlar-transit sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 Å Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown OBSTRUCTIVE SLEEP 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No မ 1 YInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural (Month, Day, Year) 5 \square Pending 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. The definition of the desired of the (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00065097 AUGUST, 14, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DY JANAKI DEEPAK 301 HOSPITAL DRIVE, GLEN BURNIE, MD 31. Date filed (Month, Day, Year) State 32. Paist Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

			Pleas	se Type or Prin AMEND ITEN State of Mai	t in Blac M#20b,c	k Indelible l perFH, G90	nk. Ensure	All Copie	es Are	e Legible	
			For State Registrar	State of Ivial		Certificate of		i ivientai n	Reg. N	2010	
	Physicia Medic		1. Decedent's Name (First, Middle,	1. Barks	dale	III		2. Date of D	Death	ay//. 2001	3. Time of Death 1/43 am
	Examin		4a. Facility Name (If not institution, a	ive street and number)	ospital	4b. City, Town	or Location of Dea	athy fif	40	c. County of Dea	th
	Funeral Director		5. Social Security Number 2 3 0 - 2 0 - 7 1 1 9	i. Sex 7. Age (i	In yrs. last birtho	day) If Under 1 Year Months Day			Birth	19. Bir	thplace (State or Foreign
		or	Usual Residence of Decedent 10a. State 10b. County	1	10c. City, Town	or Location		Daty	10,11	<u>SCI 1 V 1</u>	10d. Inside City Limits
	r 28a-f s notified	Direct	10e, Street and Number	A	Ba	Himor 10f. Zip Code	-e		10- 0	itizen of What Co	1 X Yes 2 □ No
le	th with the ms 23a comust be	Funeral Director	2131 Hers	pert St	t.	21	217			US.	A
336	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	d 12. Was Decedent Ever Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates.		13. Was Decedent of If Yes, specify Cu	ıban, Mexican, Pue	Specify Yes or No rto Rican, etc.)	D-	14. Race - Ame Black, Whit Specify:	
15-0	72 hours n "natur Aedical I	Completed	15. Decedent' (Specify only highest	s Education grade completed)		Decedent's Usual Occ Give kind of work don fe. DO NQT use retire	e during most of w	orking	16b. l	Kind of Business	Industry
212	d within lygiene. ther thai nt, the N	Be Cor	Elementary/Seconday (0-12)	College (1-4 or 5+)		Labore	2		M	d. Cuj	- Company
land	d be file Mental H arked of	To B	17. Father's Name (First, Middle, Las George W	Barks	dale	Jr.	18. Mother's N	ame (First, Middle	e, Maiden	Surname) DML1	- ' '
Mar	12 should lith and M 27 is ma r traumat		19a. Informant's Name/Relationship	(Type, Print) (Wil	fe) 19b.	Mailing Address (Street	et and Number or F	Rural Route Numb	per, City o	r Town, State, Zi	o Code)
\mathcal{G}_{ℓ} Baltimore,	Page 1 and ment of Heal ant: If item ury or other		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Sp.		20b. Place of I	Disposition (Name of Crematory or other p	1	/20/2010	20c. L	ocation - City or	Town, State
Baltir	permit. P Departme Importar any injur		21. Signature Funeral Service Lice		111011	22. Name and Ado		Funer	al H	lome P.	A
Ī			23a. Part 1. Enter the disease, or shock, or heart failure. List only	omplications that baused the	ne death. Do no	enter the mode of d	ying, such as cardia	ac or respiratory	arrest,	. Md! 2	Approximate Interval Between
	Ph_sician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Septi	cemic	2					Onset and Death
	Examiner	-i-	Sequentially list conditions,	10n- ST		ation M.	yo cardi	al In	larc	tion	
	executed an and rial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to (or as a c	Farlua.	e					
09	e ar		resulting in death) Last	Due to (or as a c		:					
Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at ti 9 Unknown	Fetal death	3 Ectopic pregna 5 Other (specify)				23d. Date of de Month	livery Day Year
P.O.	s that the gned by t e detach		Part.ll. Other significant condition	s contributing to death but	not resulting in	the underlying cause	given in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
ords,	requires been sig should b	Completed by	LINDIR4 DSTO	rellitus +	gre I	<i>F</i>		1 = 24a. Wa:		24b. Were au	robably 4 WUnknown topsy findings available
Reco	rsician: The law r s certificate has b director, page 2 s	Comp	Nypercraise					auto	opsy formed?	prior to death?	completion of cause of
/ital	s certific	To Be	25. Was case referred to predical examiner? 1 Yes 2 No	Hospital:	t 2 🗍 FR/Outr		Place of Death (Ch	eck only one) Home 5 \square Res	oidonno (6 Other (Spec	56A
Jou	ing Phy I. After this uneral o		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Y	28b. Tir	ne of 28c. Inj	ury at ork?	28d. Describe			
ivisior	or Attend after death Director: / in by the f	Certificate:	2 Accident Investiga 3 Suicide 6 Could no 4 Homicide determin	t be	- At home, farm Specify)	M 1	Yes 2 No		(Street an		ral Route Number,
ā	To the Hospital or Attending Physician; The la within 24 hours after death. To the Funeral Director: After this certificate he completed filled in by the funeral director, page:	Medical	(Check 2. Medical Exa	hysician: To the best of my aminer: On the basis of exar	mination and/or i	nvestigation, in my opi	nion, death occurred	d at the time, date	and place	e, and due to the	cause(s) and manner stated.
	To the within of To the comple	Ź	only one 3 Li Certifying N	erse Practioner: To the be		29c. Licer	nse number		29d. Da	(s) and manner as	
N	•		30. Name and address of person with	Mehriz peompleted cause of deat		ge, Print)	89666 Bend 6	Terron	0 :	LIXOT	al
	Stat Registra	e	31. Date filed (Month, Day, Year)	32. Registrats	Signature.		wie 0		_ /	ا ، الإرب	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 13, 2010 ear Grace M. Birkmaier 8:05 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist Center Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** August 5, 1920 1 □ M 2 □XF Months Days Hours 232-26-1318 90 Washington, DC **Director** Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director Harford Bel Air 1 Yes 2 Xio MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 1303 H Scottsdale Drive 21015 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces' Black, White, etc Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 Specify: white 1 Yes 2 No Specify: and Mental Hygiene.

is marked other than "natural", 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) At Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ည Ralph E. Clark Margaret P. Coleman permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic tonce. other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21015 1303 H Scottsdale Drive-Bel Air, Maryland Karen Ermer-daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Dulaney Valley
Memorial Gardens 1 Burial 2 Cremation 3 Removal from State Timonium, Maryland Aug. 17,2010 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Evans Funeral Chapel and Cremation Services
8800 Harrord Road Parkville, Maryland 21234 13 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Due to (or a consequence of) tleart Failure disease or condition VEUVS Medical resulting in death) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Dav Year 1 Yes 2 L 9 Unknown 9 I Ilnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by chronic icidney disease unnum truct intectin 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed Yes 2 prior to completion of cause of death? has To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 2 🗆 No 1 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D70635 MD

DHMH 17 Rev 7/2009

Registrar

Chartes

suite 4105 Bultimore, ND 21204

Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701

Patel

31. Date filed (Month, Day, Year)

or Town, State)
1133 Courtney Rd, Halethorpe, Md. determined (Specify) house Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year, State

Registra

Ana Rubio MD.

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

August 12, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 8 16 Day ັ້ 2ີປັ່ງ 10 3:45 PM Antoinette C. Carmen Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Future Care Canton Harbor Baltimore City Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2X□ F Months Hours Min 5/22/1915 175-30-5544 95 Yrs Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 1X Yes 2 ☐ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral 2304 Foster Avenue 21224 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ō þ 1 Never Married 2 Married 1 🗌 Yes 2 🔀 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural" Specify: Completed 3€ Widowed 4 Divorced White Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. I other than ' life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Homemaker Own Home Be nt of Health and Mental Hit: If item 27 is marked of 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Ignatius Mikelionis Anna Urbonas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2304 Foster Avenue, Baltimore, MD 21224 James D. Carmen, Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Department o Important: If any injury or once. ò 1🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State Dominic's Cemetery 8/21/2010 Philadelphia, P.A. 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licensee 22. Name and Address of Facility Reilly Funeral Home, Inc. Timothy Harman 2632 E. Allegheny Avenue, Philadelphia, PA 19134 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ neu morua disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year 2 No 9 Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chromic Obshuctive Pulmonary Disease 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: မ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at e Hospital or Attending P 24 hours after death. Funeral Director: After t 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No injury 1 🔀 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

Registrar DHMH 17 Rev 7/2009

State

only one)

29b. Signature and title

Mello n.

(une mo

32. Registrat's Signature

29c. License number 00/1/50

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MELITO M. TOROBI MO 441 S. ELLWOOD AVE. BALTO, MD 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Of Maryla 1 - State Registrar		artificate of D			2010	25783			
	Physicia		1. Decedent's Name (First, Middle, Last)				2. Date of Death Month () 8		3. Time of Death			
	Medic Examin		4a. Facility Name (i) not institution, give street and number)		4b. City, Town, or		1	4c.,County of Dea				
المهمد	Funeral		5. Social Security Number 6. Sex 1 \sum 2 F 7. Age (in year)	. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	Yearh 20 ACA	thplace (State or Foreign			
	Director		Usual Residence of Decedent	+ Yrs.			159pt. 15	19352 10	CAROLINA			
	daryland 8a-f sho tified at	rector	MD Baltimore H	alethor	(PP)				10d. Inside City Limits 1 Yes 2 No			
	vith the h 23a or 2 st be no	Funeral Director	10e. Street and Number 200 FiRST AVE.		10f. Zip Code	1		og. Citizen of What Co	ountry?			
350	nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland artiment of Heath and Mental Hygiene. A cartent of Heath and Mental Hygiene. I cantant if time Z7 is marked other than "natural", or items 28a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at e.e.	þ	11. Marital Status 1 Never Married 2 Married l·	Was Decedent of His f Yes, specify Cubar	n, Mexican, Puerto	pecify Yes or No- po Rican, etc.)	14. Race - Ame Black, Whit Specify: B	e, etc.				
15-0036	72 hours I "natura edical E	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give I	dent's Usual Occupa kind of work done d		king 1	6b. Kind of Business	<u>_</u>			
	l within / /giene. ner than t, the M		Elementary/Seconday (0-12) College (1-4 or 5+)	Silife. Di La	O NOT use netired) UOK	er	(State or	MD			
land	d be filed dental H irked ott tic even	To Be	17. Father's Name (First, Middle, Last)		Į.	18. Mother's Nan	ne (First, Middle, Ma	aiden Surname)				
Mary	2 should th and N 27 is ma trauma		19a. Informant's Name/Relationship (Type, Print) Danzell T. Cutter	19b. Mailin	ng Address (Street a	and Number or Ru	ral Route Number, C	City or Town, State, Zi	p Code)			
	Page 1 and nent of Heal ant: If item ury or other		20a. Method of Disposition 20b Burial 2 Cremation 3 Removal from State	Place of Dispo cemetery, cren	sition (Name of natory or other place		Date 2	0c. Location - City or				
saitimore,	permit. Page Department of mportant: If any injury or once.		4 Donation 5 Other (Specify) 21. Signatury of Funeral Survice (Security)	oudon	Name and Addres			altimore,	mo			
מ	lmp Pep Imp any onc		23a. Part 1. Inter the disease, or complications that caused the de	b	70 Fred	hilton 1		Me PA. Us. Mo S	Approximate			
-)	hysician/ Medical		shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a conse		- 1				Interval Between Onset and Death			
	Examiner	ler	Sequentially list conditions, b. Cardio	enic.	Shock	<u> </u>		-	Hours			
	to the hospital or Attending Physician: The law requires that the death certilicate be executed within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.	cal Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last c. Atrial and Pulmonary artery thrombus Days Due to (or as a consequence of):									
00/00	rtificate ing physes as the	/Medi	IF FEMALE:						-			
DOX O	Attending Physician: The law requires that the clearn cert ectors of death. ector, Affer this certificate has been signed by the attendir by the funeral director, page 2 should be detached for use.	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Unknown 23c. If yes, outcome of preg 1 Live Birth 2 Fe Fe Fe Fe Fe Fe Fe	etal death 3 🗌	Ectopic pregnancy Other (specify)	У		23d. Date of de Month	blivery Day Year			
	rires that t signed b lid be deta		Part II. Other significant conditions contributing to death but not r	-			23e. Did toba	_	o the cause of death?			
Records,	has beer ge 2 shou	Completed by	ulcer disease, history		,		24a. Was an autopsy perform	prior to death?	topsy findings available completion of cause of			
אונשו ע	ertificate cctor, pag	Be Co	25. Was case referred to medical examiner?			ace of Death (Chec	1 ☐ Yes 2	☑No 1 ☐ Ye	s 2 No			
	g rhysic er this co ieral dire	မ	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ 27. Manner of Death 28a. Date of injury	28b. Time of	28c. Injury	4 ∐ Nursing H rat	ome 5 Residen	ice 6 Other (Spec r injury occurred	cify)			
io uoisino	death. ctor; Aft y the fur	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	injury		Yes 2 No	28f Location (Stre	et and Number or Ru	ıral Route Number			
2	ortal or A		4 - nomiciae aeterminea building, etc. (Spec	cify))	City or Town,	State)				
	lo the Hospital or within 24 hours afte To the Funeral Dir completed filled in	Medical	29a. Certifier 1 Certifying Physician: To the best of my kno (Check 2 Medical Examiner: On the basis of examinat only one) 3 Certifying Nurse Practioner: To the best of	tion and/or invest	igation, in my opinior	n, death occurred a	at the time, date and	place, and due to the	cause(s) and manner stated.			
	To virt		29b. Signature and title of certifier AD AD AD AD AD AD AD AD AD A		29c. License		<19755 29	d. Date signed <i>(Mont.</i>	h, Day, Year)			
			30. Name and address of person who completed cause of death (Ite				,		MD 2/201			
	Stat	e	31. Date filed (Month, Day, Year) 32. Registrar's Sign		446 3	1 /0 7	VIII, D	out unore	IN MACI			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_ For	State of Mary	/land / De	partment of I	Health and M	lental Hy	giene	010	05701		
		State Registrar		С	ertificate of	Death		Reg. NZ	010	25784		
Physicia Medi	an/ cal	1. Decedent's Name (First, Middle, La MARGARET	A.	DEH	\checkmark		2. Date of Dea	Day Day	707°U	3. Time of Death		
Examir		4a. Facility Name (if not institution, give	· · · · · ·	^		or Location of Death			ounty of Death			
		689 Winding Stream 5. Social Security Number 6.5		yrs. last birthda	Oden If Under 1 Year		8. Date of Birt		ne Arui	place (State or Foreign		
Funeral Director		030-24-0221	I □ M 2 Ø F 77	Yrs	Months Days		1(10nth, Pa		Cour	ntry) MA		
land show dat	ţo	Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or	Location					10d. Inside City Limits		
Mary 28a-1 notifie	Jirec	MD Anne Art	undel	Odento:						1 🗌 Yes 2 💢 No		
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10e. Street and Number 689 Winding Street	am Way #103		10f. Zip Code 21113	3		10g. Citizer	n of What Cou A	ntry?		
r death		11. Marital Status	12. Was Decedent Ever Armed Forces? 1 Yes 2 X No	in U.S. 1	3. Was Decedent of H	Hispanic Origin? (Spe an, Mexican, Puerto	cify Yes or No- Rican, etc.)	14.	Race - Americ			
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. In frem 27 is marked other than "natural", on my injury or other traumatic event, the Medical Example.	ed by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐ Yes 2 X No If Yes, Give Year or Dates.		1 ☐ Yes 2 🛣 No	Specify:		Spi	ecify: Whi			
72 hound the maternal	Completed	15. Decedent's l (Specify only highest g	rade completed)	16a. De	cedent's Usual Occup ve kind of work done DO NOT use retired;	pation during most of worki	ng	16b. Kind	of Business In	ndustry		
212 within giene.		Elementary/Seconday (0-12)	College (1-4 or 5+)		me Maker	,			Own Ho	me		
and be filed antal Hy ked ott	To Be	17. Father's Name (First, Middle, Last) Eugene Merullo				18. Mother's Name Mabel	e (First, Middle, Fontana		name)			
aryl should I and Me is marl		19a. Informant's Name/Relationship (Type, Print)	19b. M	ailing Address (Street	i			wn, State, Zip	Code)		
e, M and 2 s Health em 27		Robert Dehn 20a. Method of Disposition	Son		O Tasker I							
mor Page 1 nent of l int; If it		1 ☐ Burial 2 🖾 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	Removal from State	cemetery, c	rematory or other pla del Cremat	ce)	Date -2010		tion - City or Ti ton Ma:			
Baltil permit. F Departm Importa any inju		21. Signature of Funeral Service Licen			22. Name and Addre	ess of Facility Son Funera	1 Home	& Cre	matory	, P.A.		
		23a. Part 1 Enter the disease, or con			1411 Annap	olis Road	Udento	n Mar	yland	21113 Approximate		
Pnysician/	2 2 14	Interval Between Onset and Death Oscillation Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death										
Medical Examiner		resulting in death)	a. Due to (or as a co		4/					<u> </u>		
	ner	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as a co	nsequence of):					-			
cuted	xami	if any, leading to immediate cauce. Enter Underlying Cause (Disease or linjury that initiated events	c									
'60 ate be executed bhysician and the burial-transit	dical Examiner	resulting in death) Last	Due to (or as a co	nsequence ot):								
8760 tificate b ng physic as the b	Medi	IF FEMALE:	- u.									
Box 687(death certificat he attending pt led for use as th	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p 1 Live Birth 2 4 Pregnant at time	Fetal death	B	су		230	d. Date of deliv	very Day Year		
P.O. By that the de ned by the	hysi	1 Yes 2 No 9 Unknown	9 🗆 Unknown		,,,,,,							
S, P.(res that signed to be de		Part II. Other significant conditions of CA Lu NG		ot resulting in th	, ,	iven in Part I.	23e. Did to	,		he cause of death?		
ord: w requi	Completed by	CA CERVIX	RESULVE		·		24a. Was a	an 2	24b. Were auto	psy findings available		
Rec The lay sate has	Com	CA BREAS						rmed? 2 No	death?	ompletion of cause of		
/ital sician: certific	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	- 🗆	Toth	lace of Death (Check						
of V ng Phy ter this	te: To	27. Manner of Death 1 Natural 5 Pending	1 ☐ Inpatient 28a. Date of injury (Month, Day, Ye	28b. Time	of 28c. Injur	ry at	me 5 Resid 28d. Describe h			v)		
Sion ttendir death. stor: Af	Certificate:	2 Accident Investigation 3 □ Suicide 6 □ Could not be	n De Osa Blaco of Injury		M 1 □	Yes 2 No	006	4		I Davida Namahara		
Division of Vital Records, tal or Attending Physician: The law requires rs after death. al Director: After this certificate has been signed in by the funeral director, page 2 should be		4 Homicide determined	building, etc. (S		street, factory, office		City or Tow		umber or Hura	l Route Number,		
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 Medical Exam	rsician: To the best of my liner: On the basis of examine Practioner: To the best	nation and/or inv	estigation, in my opini	on, death occurred at	the time, date a	nd place, an	d due to the ca	use(s) and manner stated.		
To the To the Comp	≥	29b. Signature and tire of pertifier	A A	or my knowledg	29c. Licens				igned (Month,			
	_	700 Cm J	962V	(Hom 22a) (Time	Drint's	V1438		110	gens	162010		
10		39 Name and address of person who MICHAEL Ji La	a ENTA M	(Item 23a) (Type	DEFE	NSE HI	SH WAS	HA	NAPOLI) MD 21401		
Sta Registr		31. Date filed (Month, Day, Year) AUG 18 2010	32. Registrar's S	Signature Signature	Kal							
X DHMH 17 Rev 7/20	009		1-4.									
\				OPIC	INAL							

10-06095 Henderson Dunn

Amend Item 11 per spouse G914 4/4/11 dk

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 2010 25785

		1- For State Registrar			Certifi	cate of	Death			Reg. No	Э.	
Physici Medical Exam			erson D						2. Date of Month Augus		Year 10	3. Time of Death 1650 hrs
)		4a. Facility Name (if not instituti 1920 North Bentalou		eet and number)		4	b. City, Town, o Baltimore	vn, or Location of Death 4c. County of Death				
Funeral Director		5. Social Security Number 212–46–6753	6. Sex	1	e (In yrs. last b	oirthday) 65 Yrs.	If Under 1 Ye Months Da		Min.	of Birth(MN 9-1945	//DD/YYYY) 9. Bir Foreig Co	thplace (State or gn nuntry) MD
any		Usual Residence of Decedent 10a. State 10b. County			10c. City, Tow	2-2-1	200					10d. Inside City Limits
	'n	MD n,	,			Baltin						1 X Yes 2 No
th the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number					10f. Zip Code			10g. Ci	itizen of What Cou	ntry?
with the s 23a o		1920 N. Bentalou		Was Decedent	Ever in U.S.	13. Was	212 Decedent of H		jin? (Specify Yes	or No-	USA T14. Race - Amer	ican Indian, Black,
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	Funeral	1 Never Married 2 X N 3 Widowed 4 X Bi	1arried 1 vorced If Ye		No	If Ye		n, Mexican,	Puerto Ricán, etc		White, etc.	
ours aft atural"	d by	15. Decedent's Education (Spe	or D	ates:	pleted) 16a	a. Decedent	s Usual Occupa	ation (Give k	kind of work done	16b.	Specify. African-American b. Kind of Business/Industry	
36 nin 72 ho e. than "n dical Es	Completed	Elementary/Secondary (0-12)	(College (1-4 or 5	i+)		st of working life Laboratoi			- 1	Sinai Hospital	
5-00 ed with Hygien other	Com	17. Father's Name (First, Middle	, Last)				Takorako.	-	s Name (First, Mic	ddle, Maidei		pruu
121 d be fil fental E arked	Be	Henderson Dunn Sr.							essie Tali			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injurycy other traumatic event, the Medical Examiner.	7	19a. Informant's Name/Relations Angie Michele Dunt									City or Town, State	
Ore, es l and of Heal If iten ther tra		20a. Method of Disposition 1 Disposition 2 Crematio	n 3 🗌 R	emoval from Sta	te crema	atory or other			Date	Location - City or		
ltim it. Pag irtment ortant:	-	4 Donation 5 Other S 21. Signature of Funeral Service		7	Garr				8-24-2010		wings Mills	s, MD of Balto. Co.
Ba perm Imp		XIIIIIIIIII		allell	(e)	i .			•			i iaiw. w.
. Physician ⊊/Medical		23a. Par I. Enter the disease, or failure. List only one cause	on each lin	ie. ∛								Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)		heroscl				lar di	isease c	omplio	cated by	Death
	١	Sequentially list conditions,	b			<i>J</i> F						
	Examiner	if any, leading to immediate Lose. Enter Underlying Cause Due to (or as a consequence of): Cuse. Enter Underlying Cause Cu										
Mr id		events resulting in death) Last	Due to	o (or as a conse	quence of):							
760, frate be executed physician and the burial - transit	/Medical	X UNPENDED	Х ам	ENDED #I as n	oted,	23a,2	7,28a-f	per N	4E g907	9.27/1	10 TT	
18760, tificate being physicias the buria		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		c. If yes, outcom	e of pregnanc	У		Ectopic		23	Bd. Date of delivery) Day Year
Box 68 e death certif the attending	Physiciar		known 9	Pregnant at t	ime of death	=	er (Specify)					
cords, P.O. Box 68 law requires that the death certif has been signed by the attending 2.2 should be detached for use as	by Ph	Part II. Other significant condit	ions contr	All the second second	but not resulti	ng in the un	derlying cause	given in Par				the cause of death?
dS, Fragures 1									_	Yes 2		topsy findings available
e law re has be	Completed	-] _	autopsy perform <u>ed</u> ?	prior to death?	ompletion of cause of
tal Rectinan: The certificate ector, page	οl	25. Was case referred to medica	1				26.Place	of Death (Check only one)	Yes 2 1	No 1 Ye	S 2 No
Vita	TOB P	examiner? 1 Yes 2 No	Hospita	I I II patiei		Outpatient		-	Nursing Home		ence 6 🗸 Other	: Scene
Division of Vital Records, P.O. rat or Attending Physician: The law requires that th rs after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach		27. Manner of Death 1 Natural 5 Pend	dina _	8a, Date of Injur (Month, Day,Ye	ar)	Time of Inju	1	ry at Work? Yes 2 ဩ I	1	ribe how inj	jury occurred	
Visic or Atter fler dea birector	Certification:	2X Accident Inve	stigation E	7d 8/14/ 28e. Place of Inji		5:35 farm, street,		ouilding, etc.		ion (Street	and Number or Ru	ral Route Number, City Bentalou St
Di spital hours a neral I				(Specify)	Hous	e			Balti	wn, State) more,	MD N.	Jenearou Be
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only	miner:On th								nd manner as state ace, and due to the	
F 3 F 3	ž	29b. Signature and title of certifie		Tide in the control of		·	29c. Licens	e number		29d.	Date signed (Mor	nth, Day,Year)
_ \		Mayone Me	Mul	l			O.C.	M.E.		Aug	gust 15, 2010	
oxpend	-	 Name and address of person Margarita Korell MD. 		eted cause of de ant Medical {	, ,		n Street, B	altimore,	MD 21201			
St	ate	31. Date filed VG th 18 20		32. Registrar		ale		·				
Regist	rar	HOO TO SO	W /63		p. 19							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2010 Year **Physician** August 16, 4:30 A M ragin /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Catonsville Baltimore Charlestown Care Center Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, **Funeral** Months Days Hours Min 1 M 2 F 5/24/14 96 Maryland Director 215-46-9720 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County "natural", or items 23a or 28a-f show 1 ☐ Yes 2 No Director MD Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 21229 USA Funeral 610 Nottingham Road 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ※ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐Yes 2 🗷 No Specify Specify þ 3 ₩ Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any Injury or other traumatic event, Ire Magnobe. Elementary/Secondary (0-12) College (1-4or 5+) Home Housewife 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Chesno ပ Frank_Chesno 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Unit B101 Columbia, Md. 21045 5960 Mulrace Ct. Victor Dragin / Son 20b. Place of Disposition (Name of Baterian Personal Party Company) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park 8/21/10 Baltimore, Maryland 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Iricensee 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part 1. En / r the disease, or shock, or heart failure. Lis mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line Immediate Cause (Final disease or condition resulting in death) hount **Physician** Congestive /Medical Due to as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to for se a consequence of Hospital or Attending Physiclan: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) P.O. Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐Yes 2 ☐No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Man of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only Medi and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 0 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Catensville, MD Michael 31. Date filed (Month, Day, Year) 32. Registrar's State AUG 182016 Registrar

DHMH 17 Rev 1/2001

1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 08 Physician/ 1:45 AM M 2010 James Leonard Fisher Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner 2525 Pot Spring Road T<u>imonium</u> Baltimore D P 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Days Hours Min. 04/10/1924 Maryland 86 **Director** 219-18-5128 Usual Residence of Decedent or 28a-f shov notified at shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director 1 🗌 Yes 2 🔀 No MD Baltimore Timonium ö 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should re filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is mar ed other than "natural", or items 23a or amy rijury or other traumati event, the M-dical Examiner must be a once. Funeral 2525 Pot Spring Road 21093 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Black White etc. þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates. WW II Specify: White Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 <u>Attorney</u> Law Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) TAMES ည Elmer Truman Fisher Bessie Deland Rexroth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timothy J. Fisher P.O. Box 236 - Kingsville, Maryland 21088 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salem U.M. Church Cem. 08/19/2010 Upper Falls, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland aasa 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physicianz SC disease or condition Medical resulting in death) o (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): -transit that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician at for use as the burial-Physician/Medical requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₽ Q Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed neec 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law 24 hours after death.

Funeral Director: After this certificate has page 2 s autopsy performed 1 Yes 2 No Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home Statement 6 Other (Specify) 2. No 1 🗌 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifie 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year)
August 16, 2010 29b. Signature and title of certify 29c. License number 30 Name and address of person cause of death (Item 23a) MD 21093 MUINOWI State Registrar

191180

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of M	arylan		artment of H		and M	lental Hy	giene	010	0.700	
			1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death								010	25788		
	Physicia Media			nklin						2. Date of Dea	ath	2010	3. Time of Death 7:04 P M	
	Examir		4a. Facility Name (if not institution,	give street and number)			4b. City, Town, or	Location	of Death		4c. Co	ounty of Death		
-/	/		University of				Bain					N/A		
	Funeral Director		5. Social Security Number 420 52 2777	6. Sex 1 M 2 F	e (In yrs. Ia 70	nst birthday) Yrs.	If Under 1 Year Months Days	Hours	Min.	8. Date of Birt (Month, Da 01/23		9. Birth	place (State or Foreign ntry) a Dama	
	ryland I-f show ied at		Usual Residence of Decedent		1 -		<u> </u>	J		-01/23	/ 1) 40			
		Director	10a. State 10b. County Maryland Ann	e Arundel	· ·	, Town or Lo Severn							10d. Inside City Limits 1 ☐ Yes 2 🛣 No	
	the Ma or 28; e notif	Ę	10e. Street and Number 10f. Zip Code						···	10g. Citizen of What Country?				
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	566 Pasture Brook Road 21144							-	.S.A.	,.		
			11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S	3. 13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Or	rigin? (Spec	cify Yes or No- Rican, etc.)	14.	Race - Ameri		
36		d by	1 ☐ Never Married 2 🗷 Marri 3 ☐ Widowed 4 ☐ Divorced	ied 1 X Yes 2 If Yes, Give Year or Dates.	No Viet		1 ☐ Yes 2 🏝 No				Spe	Black, White, ec <i>ify:</i>	nite	
2-0		olete		t's Education		16a. Deced	dent's Usual Occupa	ation			16b. Kind	of Business Ir		
2		To Be Completed	(Specify only highest grade completed) Elementary/Seconday (0-12) 12th (Give kind of work done during most of working life. DO NOT use retired) Shuttle Missions Mana						ĭ	ሞኤ	o II.			
Ö O			12th 17. Father's Name (First, Middle, Le	ast)		5110	Turie Mis						ers Company	
Baltimore, Maryland 21215-0036			Thomas Franklin						other's Name (First, Middle, Maiden Surname) Edith Snea					
/au			19a. Informant's Name/Relationsh				ng Address (Street a							
e) Le			Joan Franklin 20a. Method of Disposition	/ Wife	Janh Di	<u> </u>	Pasture E	3rook					nd 21144	
πor			1 ☐ Burial 2 🛣 Cremation 4 ☐ Donation 5 ☐ Other (S)		CE	emetery, cren	natory or other plac Crematory			ate 6/2010		ion - City or T	own, State Maryland	
a E			21. Signature of Funeral Service Li		Day									
<u> </u>	마스트 등 등 Hysician Medical Examiner		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225											
			23a. Por 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Sequentially list conditions, b.											
7			Immediate Cause (Final disease or condition resulting in death)	a. Pylmo	nary	HOU	nornac	95					Onset and Death	
				Corora	T WA	de to	a Disc	-0.10	63					
	7 ±	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	D. Due to (or as a	i conseque	ence oij.	7	het d'A				-		
P	be executed sician and burial-transi	Examine	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a	conseque	ence off:								
9	ate be executed physician and the burial-transit	dical	is a security and	d										
9/89	tificate ng phys as the	Med	IE ESMALE:	T										
9 X	ith cert ttendir or use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy							23d. Date of delivery Month Day		,		
P.O. Box	re dea / the a ched f	hysic	1 ☐ Yes 2 No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown								MONTH	Day Year		
J.	that the	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death?			
ďS,	equires een sig ould b	ted	Renal Failure							1 Yes 2 No 3 Probably 4 Unknown				
or Vital Records,	has be	Completed								autopsy pri		4b. Were auto prior to co death?	e autopsy findings available r to completion of cause of	
ř	nysician: his certific		25. Was case referred to medical				OC DI-	t D	Al- (Ol I	1 Yes		1 Yes	2 🗆 No	
<u> </u>		To Be	25. Was case referred to medical examiner? 1											
<u></u>			27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injur	у [2	28b. Time of injury	28c. Injury work?	at		8d. Describe ho			/	
Sion	ttendi death stor: A / the fi	Certificate:	2 Accident Investiga 3 Suicide 6 Could n	ation ot be	n. At han	no form stre		Yes 2 🗆		0.1				
DIVISION	s after		4 ☐ Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)				
_	Hospit	Medical	29a. Certifier (Check only one) 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 **Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
	No the vithin somple	Σ	only one) 3 L Certifying I 29b. Signature and title of certifier	lurse Practioner: To the b	oest of my	knowledge, d	eath occurred at the 29c. License	time, date	and place,	, and due to the	cause(s) and	manner as st gned (Month,	ated.	
			mae	(BM104TH)	MD		1518	829	3240	2		1 13, 2	*	
	5+1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MONA BANUUTU 22 South Greene Street, Baltimore MD 21201											
	Stat	٠,	31. Date filed (Month, Day, Year)	32. Registra	r's Signatu	ire	1	.,	• /					
	Registra	r	AUG 18	CHAN THE	4	4	and .							

Please Type or Print in Black Indelible inkt Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month hilip D. Greene 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Union Memorial Hospital Baltimore n/a Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8 Date of Birth Funeral Sex 1 M 2 □ F Months Days Min (Month, Day Year) 214-62-6285 56 Director Usual Residence of Decedent 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 🔀 Yes 2 ☐ No MD n/a Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21215 3915 Callaway Avenue USA items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 X Never Married 2 ☐ Married "natural", or à Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: African-American Completed 3 Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical Give kind of work done during most of working life. DO NOT use retired 15. Decedent's Education 16a. Decedent's Usual Occupation tV a 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) 12th College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Harry I. Greene Jr. Maggie Ferguson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) pernit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau Margaret Hoard/Sister <u>3332 Ripple Road, Baltimore, MD 21244</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date X Burial 2 Cremation 3 Removal from State King Memorial Park 8-18-2010 Woodlawn, MD Donation 5 Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. of Baltimore Co. 21. Signature of Funeral Service Licenses 9200 Liberty Road, Randallstown, MD 21133 art I. Enter the disease, or complications that collect the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immulate Cause (Final Cardiac arriv Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ngestive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying rusu, suspected Exami physician and the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last bacterial peritonits pontaneous Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia. attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 1 Yes 2 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 No 1 Yes ဥ 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Man of Death 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred 1 W Natural 5 Pending within 24 hours after death.

To the Funeral Director: Ai completed filled in by the fu 2 Accident
3 Suicide
4 Homicide 2 No 1 Yes Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Praction | T. the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009 31. Date filed (Month, Day, Year)

Box 68760

P.O.

Division of Vital

5altim skemo

Paca St.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 2ď10 рм He]en Gipprich 10:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bel Air Health and Rehabilitation Harford Bel Air Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min Sept. 20 92 °1917 Mary Tand **Director** 215-07-2929 Usual Residence of Decedent 10a. State 10c. City, Town or Location with the Maryland 10d. Inside City Limits **Funeral Director** 28a-f 1 🗌 Yes 2 🏻 No Md. Harford Bel Air 10e, Street and Number ò 10f. Zip Code 10a. Citizen of What Country? 21014 USA 701 Mayton Court Page 1 and 2 should be filed within 72 hours after death 1 nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 X Widowed 4 Divorced White Year or Dates marked other than "natur imatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Secretary Retail 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Konstantin Marv Decevich 0po1ko 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Stephen Gipprich/Son 701 Mayton Court Bel Air, Md. 21014 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley Mem. Gdns. 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Important: If 8-20-10 Timonium, Md. injury o 4 ☐ Donation 5 ☐ Other (Specify) Signature of Jones Service Licen 22. Name Ruckd Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ VIC disease or condition Medical resulting in death) equence of Due to (or as Examiner 12 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of, Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ Month Year signed by the a 1 Yes 2 1/2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autonsy perform death? 2 No 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 No ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending

Box 68760 P.O. Division of Vital Records, the funeral director. e Hospital or Attending Pl 124 hours after death. e Funeral Director: After t

2 Accident
3 Suicide
4 Homicide

(Check

only one) 29b. Signature and

Investigation 6 Could not be

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Medical

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number,

City or Town, State,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Ruby Helen Month **Physician** Hawkins August 2010 /Medical 4a. Facility Name (If not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death Examiner porchaster Gerralal Spital Cambridge Dorchest 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, 218-40-6167 **Funeral** Year) Months Days Hours Virginia 1 ☐ M 2 🗶 F Director June 3.1944 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State Md • 10d. Inside City Limits Dorchester Cambridge permit. Pages 1 and 2 should be filed within 72 hours after death with the Mary Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sham Injury or other traumatic event, the Medical Examples of the follows. Director 1XYes 2 No 10f. Zip Code 1 613 10e. Street and Number 10g. Citizen of What Country? 819 Park lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black δ If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Laborer Seafood Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Fosque Dorothy Mae Robinson 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9703 Macks Ln.McDaniel, Md. 21647 Ollie E. Waller/ Brother 20b. Place of Disposition (Name of cemetery, crematory or other place)
Direct Cremation 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State Dover, De. 8/22/10 4 Donation 5 DOther (Specify) 22. Name and Address of Facility Young & McPherson F. 308 N. Front st. Seaford, De. 19973 23a. Part 1. Enter the disease Part 1. Enter the disease, or complication shock, or heart failure. List only one called the Complete ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Stay **Physician** obstructive -nd /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): A Cuti The law requires that the death certificate be execu and burial-trar Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.0. the 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 ☐ Yes 2 No 2 🗆 No 1 ☐ Yes or Attending Physician; After this certific funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

State Registrar 29a, Certifier

29b. Signature and title of certifie

300

31. Date filed (Month, Day

Medical

autics Rub

and manner stated.

Cambridge

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

St

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D65528

29d. Date signed (Month, Day, Year)

08/15/10

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 7 AM M au Year Grace Elizabeth Hare Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Good Samaritan Hospital Baltimore City **Baltimore** 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕅 F Months Days Hours 0272071921 Director Maryland 220-05-9259 89 Usual Residence of Decedent show at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director or 28a-f sh notified a MD Baltimore Baltimore 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code d Mental Hygiene. marked other than "natural", or items 23a or 10g. Citizen of What Country? Funeral 4224 Slater Avenue 21236 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🖾 No Black, White, etc. Completed by 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 Divorced 4 Divorced traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Sales Associate JoAnn Fabrics Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Henry John Kraus Grace Margaret Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t. Page 1 and 2 sl tment of Health a tant: If item 27 is 4224 Slater Avenue - Baltimore, Maryland Lawrence E. Hare, Sr. (husband) Important: If item 2 any injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State **Department** 4 Donation 5 Other (Specify) Gardens of Faith Cem. 08/20/2010 Baltimore, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. A. 11750 Belair Road - Kingsville, Maryland 21087 aga 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death 10 Immediate Cause (Final Physician/ mirantun disease or condition resulting in death) Medical Due to (or as a consequence of): [£]Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 \(\sum \) Yes 2 \(\sum \) No Month Day Year 1 Tes 2 P 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ZUNINMY MANY DISURSE 1 TYPS 2XXNo 3 ☐ Probably 4 ☐ Unknown URINMY MANT PNEETIUN 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 N 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ျ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined า 24 hours a e Funeral I 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Number Practiciner: To the cost of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 ho

To the Fune

completed fi (Check unly ofte 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ANK 14, 2010 715132 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NEWRYPY 1- SWILM SLVI WWW SLVD BRITMONE, MI) 21239 SWI State 32. Registrar's Si Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2010 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 08 10^{ay} 2010 4:30 PM M Agnes Evelyn Hash Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F Months Hours 02/28/1916 Marvland Director 215-10-6742 94 Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland notified at Director 1 Yes 2X No MD Baltimore Perry Hall 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Examiner must be Funeral 23a 4005 Kahlston Road 21236-1023 U.S.A. items 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. ò ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White "natural", Completed 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Filling Machine Operator Distillery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Page 1 and 2 should be a ment of Health and Menta <u>Mary Margaret Weinreich</u> William Frederick Jacob Wiegand 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. 2025 Holly Neck Road - Baltimore, Marylan Marie Clasing (sister) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/16/2010 | Timonium, Maryland Valley Mem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 6 11750 Belair Road - Kingsville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cordinny schemic Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of Physician: The law requires that the death certificate be executed Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown To Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed?
☐ Yes 2 No. death? 2 🗌 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 🗌 Nursing Home 5 🗌 Residence 6 🖾 Other (Specify) 🗥 🖔 D 🔎 completed filled in by the funeral Certificate: 27. Magner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 1 Natural Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) within 2 29b. Signature 29d. Date signed (Month, Day, Year) 2010 son who completed cause of death (Item 23a) (Type, Print) 30. Name and address of p HALVES M 670 MOI N 31. Date filed (Month, Day, Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 0 1 0 Certificate of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death 2-25AM **Physician** QD /Medical 4c. County of Death cility Name (If not institution, give street and n Examiner Sollimore VH 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🖍 F 214-50-5980 JUNE 4. 1946 Director MARYLAND Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, If a Item 1 is a month once. 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Director MARYLAND

10e. Street and Number BALTIMORE ALI Timeno 10g. Citizen of What Country? 10f. Zip Code 7404 21224 Funeral BELMONT AVE U.S. A. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 M No Specify: W HITE ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GLADYS HEINE CHARLES PHELPS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State RUSSELL W. JEHN-STON, 20a. Method of Disposition HUSBAND 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) GREEN MOUNT CEMETERY AUGUST 16, 2610 BALTIMORE CITY 21. Signature of Funeral Service Licensee 22. Name and Address of Pacility R, INC. FUNERAL HOME Catherine M. Beiles 9CIEASTERN AVE, BALTIMORE, MQ. 21231 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions. cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-tra Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 🗷 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 Probably 4 nknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 2 No 1 Thpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after deat Funeral Director: 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| General Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely and manner stated within 2 To the I

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month AN 15 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death Town, or Location of Death Balto 05 09 andalls TOW 7. Age (In yrs. ast birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 9. Birthplace (State or Foreign **Funeral** 1 ₩ M 2 🗆 F 50 Months Days Hours Min. **Director** Yrs. ar Usual Residence of Decedent 28a-f show 10a. State 10b. County . Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Eart: If item 27 is marked other than "natural", or items 23a or 28a-f sho inty or other traunatic event, the Medical Examiner must be notified at iny or other traunatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Bruce U.S.A 21217 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates. þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Completed Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname ဂ Jackson Oh 19a. Informant's Name/Relationship (Type, Print) Laughte 1 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 20a. Method of Dis osition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place Burial 2 Cremation 3 Removal from State permit. Page Department o Important: If any injury or Zion 4 ☐ Donation 5 ☐ Other (Specify) em 2010 . Signature of Funeral Service License Funerul Service P.A. 455 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death hysician/ disease or condition resulting in death) nc Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence or). signed by the attending physician and deed be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Director: After this certificate has autopsy 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? 2 No 은 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 3
Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funeral Direct 4 \square Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my only on, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Contifying Number Production To the basis of examination and/or investigation, in my only on, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Contifying Number Production To the basis of examination and/or investigation, in my only on, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of confifier 29c. License number 29d. Date signed (Month. Dav. Year) me and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year,

egistrar's Signature

10-06078 Wayne Jones

> Physician/ dical Examiner

> > **Funeral** Director

> > > any

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Baltimore, MD 21215-0036

	Please Type or Print in Black Indelible State of Maryland / Department	e In	ık. Ensure /	All Cor	oies Are L	eaibl	201	0	25796		
	State of Maryland / Department 1- For State Certificate	of of	Health and I	Mental	Hygiene						
	Registrar				2. Date of D	Reg. No eath			3. Time of Death		
n/	1. Decedent's Name (First, Middle,Last)				Month August	Day	Year		0007 hrs		
ıer	WAYNE JONES	-	b. City, Town, or Lo	ation of De			c. County of	Death			
	4a. Facility Name (if not institution, give street and number)	1	Baltimore City		aur	ľ	o. oodany o.				
	Johns Hopkins Bayview Medical Center	$oldsymbol{\perp}$			Ites To Date of	Dieth/MA	/DD/YYYY)	0 Ridh	place (State or		
	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	/)	If Under 1 Year Months Days	If Under 24 Hours			1	Foreign	1470		
	215-84-1325 1XM 2 F 48	Yrs.			10/2)/26/1961 Country) MD					
	Usual Residence of Decedent										
	10a. State 10b. County 10c. City, Town or Lo		on						10d. Inside City Limits		
	MD BALTIMON	RE							1 X Yes 2 No		
호	10e. Street and Number	_	10f. Zip Code			10g. Ci	tizen of Wha	t Count	ry?		
ĕ	Toe. Officer and Hambon										
	816 DARTMOUTH RD. APT. A		21212	-1- 0-1-1-0	/ Casaif . Van a		SA Boss	Amorio	an Indian, Black,		
Completed by Funeral Director	11. Waittai Status	. wa If Y	s Decedent of Hispa es, specify Cuban, M	nic Origin / lexican, Pu	(Specify Yes of erto Rican, etc.)	NO-	White,		arr indian, black,		
5	1 Never Married 2 Married 1 Yes 2 No		, 197 0								
Ϋ́	3 Widowed 4 Divorced If Yes, Give Year 1 or Dates:		Yes 2 X No s				Specify: I	_			
d b			t's Usual Occupation ost of working life. D			16b.	Kind of Bus	iness/In	dustry		
ete	Elementary/Secondary (0-12) College (1-4 or 5+)										
ldu	12 YA	ANNAPOLIS JUNCTION									
ő	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)										
Be (JAMES EARL JONES, SR.			GEN	EVA EDM	OND					
To E	19a, Informant's Name/Relationship (Type, Print)	ailing	Address (Street a	nd Number	or Rural Route	Number,	City or Town	, State,	Zip Code)		
۲	I I	16	DARTMOUTE	RD.	APT. A	BAL	TIMORI	E, M	D 21212		
	20a Method of Disposition 20b. Place of Di	b. Place of Disposition (Name of cemetery, Date 2						20c. Location - City or Town, State			
	1 VRurial 2 Cremation 3 Removal from State crematory				ADE:	RE MD					
			ORIAL PARE	3/20/201	BALTIMORE, MD RTON & SONS F.H., INC.						
	Signature of Funeral Service Licensee										
	James 9. Moston	17	701-31 LAT	JRENS	STREET	BALT	IMORE	<u>, MD</u>	21217		
	231. Part I. Enter the disease, or complications that caused the death. Do not er failure. List only one cause on each line.			ich as cardi	ac or respiratory	arrest, s	hock, or hea	rt	Approximate Interval Between Onset and Death		
	Immediate Cause (Final disease a Saddle Pulmonary Thromboem	ibol	ism								
	or condition resulting in death) Due to (or as a consequence of):	ooid	ont								
L	Sequentially list conditions,	CCIU	ent								
mine	if any, leading to immediate cause. Enter Underlying Cause										
Ë	(Disease or injury that initiated										
Ä	events resulting in death) Last Due to (b) as a consequence or).										
Completed by Physician/Medical	UNPENDED AMENDED										
Mec	IF FEMALE: 23c. If yes, outcome of pregnancy	-				2	3d. Date of	-			
Į,	23b. Was decedent pregnant in the past 12 months?	Fe	etal death 3	Ectopic pr	egnancy	- 1	Month	D	ay Year		
icia	Pregnant at time of death 5	0	ther (Specify)								
1VS	1 Yes 2 No 9 Unknown 9 Unknown			_				b 4 - 1 - 1	h of d		
百	Part II. Other significant conditions contributing to death but not resulting in	the	underlying cause giv	en in Part I.					he cause of death?		
ð					_ 1 _	Yes 2	✓ No 3	Prob	ably 4 Unknown		
ted						Vas an			opsy findings available		
ple		_			_ _	utopsy erform <u>ed</u>	? d	eath?	ompletion of cause of		
E			_				No 1	✓ Ye	s 2 No		
Ű		_	OC Diago o	f Dogth /Ch	neck only one)						

Division of Vital Records, P.O. Box 68760,

After this certificate has been signed by the attending physician and uneral director, page 2 should be detached for use as the burial - transit

Be

Certification:

Medical

State

Registrar

3

1 🗸 Yes

27. Manner of Death

2 🗸 Accident

0

Natural

Suicide

Homicide 29a. Certifier (Check only one)

29b. Signature and title of certifier

2

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sign completely filled in by the funeral director, page 2 should be a

6

26.Place of Death (Check only one) 25. Was case referred to medical Other₄ Hospital: 1 ✓ Inpatient 2 Nursing Home 5 Residence 6 ER/Outpatient 3 DOA No 28a. Date of Injury 28c. Injury at Work? 28b. Time of Injury Aug 6, 2010 2025 hrs 1 Yes 2 V No Pending Investigation

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Major Road

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

28d. Describe how injury occurred

Operator of motorcycle in accident

or Town, State) 700 blk W. Northern Parkway, Baltimore, MD

August 14, 2010

28f. Location (Street and Number or Rural Route Number, City

29d. Date signed (Month, Day, Year)

Patricia Aronica-Pollak MD. 32. Registraris Signature 31. Date filed (Month, Day, Year) AUG 18 2010

Could not be

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 25797 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2010 August 14 10:29A Henry Louis Kenyon Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Balto Examiner 4b. City, Town, or Location of Death Nottingham 19 Trailwood Road 5. Social Security Number 8. Date of Birth

9. Birthplace (State or Foreign

December 16,1931 County) and 6. Sex 1 M 2 □ F If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min. Months Yrs Director 217-26-8061 78 Usual Residence of Deceden or 28a-f show filed within 72 hours after death with the Maryland ian "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10a State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 🏋 No Nottingham Md. Balto. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 19 Trailwood Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 \square Yes 2 \square No If Yes, Give 1950–1952 1 \square Yes 2 \square No Specify. Year or Dates. Baltimore, Maryland 21215-0036 Specify White 3X□ Widowed 4 □ Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than "r event, the Mec Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Dry Ice Company Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oft any injury or other traumatic auces 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Adalaide Gossman John H. Kenyon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DTR. 3665 Mandolin Drive Hampstead, Md. 21074 Darleen Leslie 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other pla Gardens of Faith 1 X Burial 2 \square Cremation 3 \square Removal from State 8-18-2010 Balto.Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home Signature of Funeral Service Licenses 9705 Belair Road Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ VENTRICUL TOLE disease or condition Medical resulting in death) Examiner month ONGESTIVE Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed DISEASE HTHEROSCLEROTIC and I-tran Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Pregnant at time of death signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been sig ; page 2 should b 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed^a death? 2 🔲 No 1 Yes 2 3 Yes 25. Was case referred to medica 26. Place of Death (Check only one) 8 examiner? Other: ျှ 2 (No 1 Tes 1 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 2 Inpatient 3 Inpatient 2 Inpa 4 Nursing Home within 24 hours after death.

• the Funeral Director: After this sampleted filled in by the funeral director. 5 A Residence 6 Other (Specify) 27. Mann of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred ✓ Natural 5 Pending 1 🗌 Yes 2 🗆 No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 🗆 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Commaduely camo DOC18200 08-16-10 Nel

State

Registrar

AGANNA.

Rd, WESTM WSTER MD 211

poole

700 A

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHITRACHED

31. Date filed (Month, Day, Year)

AUG 1820

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Marvland 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. 309-30-3573 79 1-4-193 IN Director Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10a. State 10d, Inside City Limits notified at Completed by Funeral Director Zionsville Boone 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a once. 8875 Stonewick Way 46077 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2X No Black White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5 + Education School Administration Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Anna Dres Kougoufas Kosmas Kougoufas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8875 Stonewick Way, Zionsville, IN 46077 Joan Kayes (Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Merrillville, Calumet Park 8-16-2010 4 ☐ Donation ▮ ☐ Other (Specify) 22. Name and Address of Facility 7905 Broadway Merrillville, IN46410 Geison F.H. 23a. Part 1. Enter the insease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ ntracran disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** GERTIFICATION APPROVED BY MEDICAL EXAMINER Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence on: Exami that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical as the I IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year 1 Yes 2 9 Unknown Unknown the ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No ပ 1 Nnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending ☐ Natural 5 Pending 2 2010 Accident Suicide Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. The of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Streene 32. Regist State

DHMH 17 Rev 7/2009

Registrar

Box 68760^c

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 1 0 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 15^{Day} Physician/ 2010 3:55 P_{\bullet}^{M} August Leo J. Kerrigan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Timonium Stella Maris Hospice | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Days | Tully | 10 | 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Year) 923 Balt. Maryland 1 🔀 M 2 🗆 F 218-14-6890 87 Yrs. **Director** Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits 10a. State event, the Medical Examiner must be notified at Director Baltimore Timonium 1 Yes 2 No 28a-f Maryland 10f. Zip Code ò 10e. Street and Number 10g Citizen of What Country? United States Funeral 2300 Dulaney Valley Road F313 21093 of America Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 XX Yes 2 No If Yes, Give Black, White, etc. ori 1 Never Married 2 Narried à ld be filed within 72 hours after Mental Hygiene. 21215-0036 white 1 ☐ Yes 2X No Specify: Specify. "natural", 3 Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business Industry Army Corps 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) of Engineers Chauffer Be 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) marked Kathleen McDonald Leo J. Kerrigan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21093 2300 Dulaney Valley Road F313 Timonium, Maryland 19a. Informant's Name/Relationship (Type, Print) Mrs. Betty Anne Kerrigan/wife 1 and 2 s of Health item 27 i Baltimore, 20b. Place of Disposition (Name or 20c. Location - City or Town, State 20a. Method of Disposition August 18, Dulaney Valley 1 Burial 2 Cremation 3 Removal from State Timonium, Maryland 2010 Memorial Gardens 5 Other (Specify) 4 Donation Peaceful Alternatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 Sign eral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Sepsis Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year sate has been signed by the atte page 2 should be detached for 5 Other (specify) Pregnant at time of death ☐ Unknown Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No After this certificate I or Attending Physician: after death.
Director: After this certific the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE မ of 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🗶 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invising floring
State Registrar

3:55

2010

KERRIGAN

LEO

(Check

29b. Signature and title of cer

ERNESTINE WRIGHT,

30. Name and addres of p son who completed cause of death ¥tem 23a) (Typ+

MD

2300 DULANEY VALLEY RD.

29c. License number

TIMONIUM, MD

29d. Date signed (Month, Day, Year)

21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 25800 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 8 Month 3. Time of Death Physician/ 10^{Year} Alice Marie King 13 12:35 p M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Center Clinton Prince George's Co. If Under 24 Hrs. Hours Min. Social Security Number If Under **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year, 3-23-25 1 - M 2 5 F Months Days Director 85 Yrs. 198-12-6064 Usual Residence of Decedent 28a-f show 10a. State within 72 hours after death with the Maryland Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits PA 1 X Yes 2 No Philadelphia Philadelphia 23a or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 729 South Cecil Street 19143 USA items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent L.S. Armed Forces? 1 \(\text{Yes} \) 2 \(\text{X} \) No 14. Race - American Indian, Black White etc. ō ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 ▼ No Specify: "natural", Completed 3 X Widowed 4 Divorced Specify: Black er than "natur , the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 12th Housewife Private 27 is marked other r traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be file ment of Health and Mental ည George Blaino Viola Cannon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rachelle L. King 1202 Konrad Place, Philadelphia, PA 19116 Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-21-10 Philadelphia, PA Cemetery Signature of Funeral Service Licenses 22. Name and Address of Facility Clarence Johnson Jr. FH Yeadon, PA Boulevard. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Month Day 2 No 9 Unknown Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

Funeral Director: After this certificate has t autopsy performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No ျှ 1 🗌 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 1 🗌 Yes Accident Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office ilding, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one 29b. Signature ap

State Registrar

DHMH 17 Rev 7/2009

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #1 State of Maryland Department of Health and Mental Hygiene

			1 - State Registrar	e Of Warylan	-	tificate of L			Reg. No.2	LD 25801	
	Physicia		Decedent's Name (First, Middle, Last) HELEN E. LUERRSEN	Helen E	. Luer	ssen		2. Date of Dear Month Augus 1	Dav	3. Time of Death Year 05:20 AM	
	Medic Examir		4a. Facility Name (if not institution, give street and	number)		4b. City, Town, or	Location of Death	MAGNAT	4c. County of Death		
مربب	Funeral	7-	SAINT JOSEPH MEZ 5. Social Security Number 6. Sex	7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth		9. Birthplace (State or Foreign	
	Director		216-09-8826 1 ☐ M 2 🔀	1915	915 Maryland						
	ryland -f shov ied at	ctor	10a. State 10b. County		y, Town or Loc					10d. Inside City Limits	
	the Ma or 28a e notifi	Director	Maryland Baltimore Cit 10e. Street and Number	y		Baltır 10f. Zip Code	more City		10g. Citizen of W	1 ☑ Yes 2 ☐ No	
	th with ms 23a must b	Funeral	3309 Grenton Avenue				21214		USA		
Maryland 21215-0036	nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland attrent of Heatly and Mental Hygiene. ordant: If them 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at e.	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ N 3 ☑ Widowed 4 ☐ Divorced Year o	ecedent Ever in U.S I Forces? es 2 \(\) No Give r Dates.	11	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (Spen, Mexican, Puerto	cify Yes or No- Rican, etc.)		- American Indian, k, White, etc. White	
215-	n 72 ho an "nat Medica	Completed	15. Decedent's Education (Specify only highest grade comple Elementary/Seconday (0-12) Colleg	ted) e (1-4 or 5+)	(Give k	ent's Usual Occupa ind of work done of NOT use retired)	ation during most of worki	ng	16b. Kind of Bus	siness Industry	
121	iled within I Hygiene. other thar ent, the M	Be Co		/ A	Hous	ewife				ping-Own Home	
/land	ld be filed Mental Hy Iarked oth atic event	卢	Anelius Anderson				18. Mother's Name Helena	First, Middle, N. Unknowr	,		
Man	2 should the and I the and		19a. Informant's Name/Relationship (Type, Print) John Luerrsen (Son)				Avenue B				
ore,	of Heal of Heal fitem 2		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal fi	20b. P	lace of Dispos	sition (Name of patory or other place	! ,			City or Town, State	
Baltimore,	permit. Page 1 and Department of Hea Important: If item any injury or other once.		4 Donation 5 Other (Specify)	om State Par	kwood	Cemetery	8-13	-2010	Baltimo		
Ba	permi Depar Impor any ir		21. Signature of Funeral Service Licensee		22.	Lassahn 1 7401 Bela	Funeral H air Rd. B	ome altimore	e. Md. 2	1236	
	nysician/ Medical Examiner	ner	Sequentially list conditions b	at caused the death each line. ENTIL to (or as a consequence) to (or as a consequence)	A TOI ence of): GAST	r the mode of dying	g, such as cardiac o	r respiratory arre	st,	Approximate Interval Between Onset and Death 20 Howks	
00	physician and sthe burial-transit	Aedical Examiner	Cause (Disease or iinjury that initiated events c.	to (or as a conseque	ence of):						
Records, P.O. Box 68760	by the attending phase as the	Physician/Med	in the past 12 months?	outcome of pregnan ve Birth 2 Fetal regnant at time of de nknown	I death 3 🗌	Ectopic pregnancy Other (specify)	у		23d. Date Mont	of delivery th Day Year	
i, P.O.	s been signed b	۵	Part II. Other significant conditions contributing t	o death but not resu	ulting in the un	derlying cause give	en in Part I.			oute to the cause of death?	
ords	s peen s	Completed						1 Ye		B ☐ Probably 4 ☐ Unknown ere autopsy findings available	
Rec	certificate has birector, page 2 s	Com						autops: perform	y pri	ior to completion of cause of eath? □ Yes 2 No	
ision of Vital Records,	is certific director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital:	Inpatient 2 🗆 E	EB/Qutpatiant	Otho	r:				
1 Ot	death. :tor: After this r the funeral di		1 Natural 5 Pending (M		28b. Time of injury	28c. Injury work?	· _	ed. Describe hov			
Division of	rector: / by the f	Certificate	Accident Investigation Suicide 6 Could not be determined 28e. Place	ce of Injury - At hon	ne, farm, stree		Yes 2 ☐ No	28f. Location (Stre	eet and Number	or Rural Route Number.	
בות ביים ביים	ours after		, bu	Iding, etc. (Specify)				City or Town,			
So you have been determined at the time, date and place, and due to the distribution of the distribution o										o the cause(s) and manner stated	
Ė	To 1		29b. Signature arrivitle of dertifier	411	111	29c. License	number 5453	29	d. Date signed (I	Month, Day, Year)	
•		-	30. Name and address of person who completed ca	use of death (Item)	23a) (Type, Pri				DILL	21264	
	Stat	e		1 D. 7	601 O	sler I	WIVE 7	Towson	N MA	RYLAND	
	Registra	·	AUG 1 8 2010 Janua	A L							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dav Year John J. Lewis Medical 2010 $10 \, \mathrm{pm}$ 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Arlington West Nursing Center Baltimore Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under If Under 24 Hrs. 8. Date of Birth
(Month, Day, Yea
Junel 6 Birthplace (State or Foreign Country) **Funeral** 1 XM 2 F Months Days Hours Min. 225-26-3713 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits MD n/a Baltimore 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2007 Bryant Ave. 21217 USA within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces
1 1 Yes 2 1
If Yes, Give Black, White, etc. 1 Never Married 2 Married ð Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 ☐ No Specify: Black "natural", Completed 3 X Widowed 4 Divorced Army the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation permit. Page 1 and 2 should be filed within 72 l
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any injury or other traumatic event, the Meantain once. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Bethlehem Steel 8th Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Mildred Thornton Lester Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Childs/daughter Nancy Tucker Lane Apt.C3 Balto. Md 21207 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) reenMountCrematoryAug19,2010Balto.MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME
1412 E. PRESTON ST. BALTO. MD ss of Facility

B. SCRUGGS_FUNERAL HOME 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on ea Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Aine Color Due to (or as a consequence of): there sclesofz Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to a a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician کا کا کانت Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? Yes 2 No this certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital: 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital of 24 hours at Funeral D Medical 29a, Certifier 14 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 tonk laisen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature State 18 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25803 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Leonard Garry Leasure 7:40 А. м 2010 Medical August 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Joseph Richey House Baltimore 8. Date of Birth (Month, Day, Year) 02/28/1950 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours 220 56 1579 Maryland 60 Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director N/ABaltimore Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3910 8th Street 21225 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. "natural", or 1 Never Married 2 Married ğ Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Completed 3 Widowed 4 Divorced White other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Cashier Merritt Oil Corp. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leonard George Leasure Juanita Kifer permit. Page 1 and 2 should be Department of Health and Ment Important: If Item 27 is marke any injury or other traumatic e 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Penny Wilson / sister 3910 - 8th Street Baltimore, Maryland 21225 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Prosperity Christian 08/20/2010 Flintstone, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gonce Funeral Service, P.A. seum Baltimore, Maryland 21225 <u>Ritchie Highway</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Cell disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Examin physician and s the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical attending plant for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death ed by the Division of Vital Records, P.O. sate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by diabetes mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending (Month, Day, Year) 1 XNatural work? 1 Yes 2 No 5 Pending 2 Accident
3 Suicide
4 Homicide Accident Investigation within 24 hours after death

To the Funeral Director; of the Funeral Director; of the formpleted filled in by the secompleted filled in the second filled i 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 😾 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

AUG 182010

9

Leonard

ney House 828 N. Eutaw St. Baltimore, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25804 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Coll RONE 201005 10 Medical Facility Name (if not institution, give street and number **Examiner** Town, or Location of Death County of Death 8. Date of Birth (Month Day (Ugust 13) If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 38 **Director** Usual Residence of Decedent show artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho: injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location with the Maryland 10d. Inside City Limits **Funeral Director** Baltimore 1 Yes 2 No MARYLANG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Road USA 21207 hAm be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 ♣ Never Married 2 ☐ Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: 3 Divorced 4 Divorced HMERICAN 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) BAHIMORE CH EIDER Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middlq, Maiden Surname) ဂ္ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. MC RENCE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Pural Poute Number, City or Town, State, Zip Code) DARNE//-StrEET BALTIMORE, uta W atient Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery crematory or other place) 1 Burial 2 Cremation 3 Removal from State August 19,2010 atons Ville, MARY And STAR 4 Domation 5 Other (Specify) WESTERN SERVICE Sign re of Funeral Service Lice 22. Name and Address of Facility
HANCY M. WAITACE K
3405 W. FRANKLIN Street BALLIMORE, MARYLAND 21229 23a. Part 1. Enter the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Interval Between Onset and Death Physician/ hemorrhage disease or condition Medical resulting in death) **Examiner** lears Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or a a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical んんん かん Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month been signed by should be detac Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of s certificate has the lirector, page 2 st autopsy performed death? Yes 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Certificate: To I 1 🗌 Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Could not be ☐ Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral Completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one Ourtifying Nurse Practioner: To the best of my knowledge 29b. Signature and title of certifie H00659. Name and address of person who completed cause of death (Item 23a) (Type, Print) Belvedere D ed (Month, Day State 32. Registrare AUG 18 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 25805 State of Maryland / Department of Health and Mental Hygiene 2 1 1 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Thelma R. Mallonee 08-16-2010y 0955 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign Country) MD 1 □ M 2**X** F Hours 03-21-1920 218-07-4888 90 Director Usual Residence of Decedent 28a-f shov 10b. County Department of Health and Mental Hygiene. Important: yor items 23a or 28a-f sho Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MDHarford Bel Air 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 110 2C Idlewild Rd 21014 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: 3X Widowed 4 ☐ Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Smith Catherine Long 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert M. Mallonee Jr (Son) 1733 Chrisara Ct Forest Hill MD 21050 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) BelAir Mem. Gardens 08-19-2010 Bel Air, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature I Fur al Servic 22. Name and Address of Facility Schimunek Funeral Home of BelAir Inc 610 W. MacPhail Rd BelAir, MD 21014 23a. Part 1. Enter the disease, or complications that caus of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one causi Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Liner Universitying Cause (Disease or iinjury Due to (or as a consequence of): Examin that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical ending phys use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day been signed by the should be detached 9 Unknown Part II. Other significant contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law r within 24 hours after death. To the Funeral Director: After this certificate has b has autopsy page 2 performed Yes 2 Division of Vital 25. Was case refe Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 D atural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🛂 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and place, and due to the cause(s) and manner stated.

Certifying Numer Practice or To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Numer Practice or To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier Rue-MIL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

Month Day Y ar)

allonee.

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 08^M21^t5−201^{©ay} Marie Veronica Marshall 5:35 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD 8. Date of Birth **Funeral** 1 □ M 2 😾 F Days Hours Min 06-30-1919 212-01-6290 91 Director Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Harford Bel Air 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 501 Cedar Springs Rd USA 21015 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. 2 1 Never Married 2 Married 2 No 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene.
77 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Peter M. Calzone Katie Venditti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 503 Cedar Springs Rd Bel Air, MD 21015 Mary E. Murphy (Daughter) 20a. Method of Disposition
1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Bayview Crematory 08-18-2010 | Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Schimunek Funeral Home of BelAir Inc 610 W. MacPhail Rd BelAir, MD 21014 23a. Par 1. Enter the disease, or comilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line immediate Cause (Final Physician/ disease or condition resulting in death) END STAGE DEMENTIA Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Exam Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) physician the burial Physician/Medical or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Pregnant at time of death 5 Other (specify) Month Day Year Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas performe Yes 2 X No 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Tyes neral Director: / Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined on 24 hour.

o the Funeral D

completed fille Medical 1 A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier To the within 2 only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DWG1

DHMH 17 Rev 7/2009

State Registrar

2010

AUGUST

MARIE MARSHALI

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

ERNESTINE WRIGHT.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 25807 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 17, 2010 August 6:50 P M Hilda Marie McCusker Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death 14041 Prospect Rd. Airy Frederick Mt. If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** June 27,1928 1 - M XXF Days Maryland Director 212-26-1731 82 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medic J Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes XXNo MD Frederick Mt. Airy 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral U.S.A. 14041 Prospect Rd. 21771 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ★ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes XX No Specify: 3XXWidowed 4 ☐ Divorced Specify: White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 12 Retail Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) <u>0</u> Agnes Leaf Walter Berryman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14041 Prospect Rd. Mt. Airy, Maryland 21771 Linda Holler / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemeter, crematory or other place)
Druid Ridge
Cemetery XXBurial 2 Cremation 3 🗋 Removal from State 4 ☐ Donation 5 ☐ Ather (Specify) 8/20/10 Pikesville, MD 21. Signature of Fundal Service Icenses 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 1605 Reisterstown Rd. Owings Mills, MD21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ 10940 811714 disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the bunal-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 month's?

1 Yes 2 Yo Month Year Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown s been signed by the should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed Yes 2 1 Yes 2 140 this certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 AResidence 6 Other (Specify) 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work 1 🗌 Yes 2 No Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 555 South Center St. Westminster, MD21157 mo State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	State of Marylar		rtment of H ificate of L		1ental Hy	_	2010	2 =	000	
	Registrar 1. Decedent's Name (First, Middle, Last)	Cert	incate of L	Jealli	2. Date of De		2010	3. Time o	808 f Death	
Physician/ Medical	James L. Merryman				Augus	ust 12, 2010		9:49	Рм	
Examiner	4a. Facility Name (if not institution, give street and number) Catonsville Commons			Location of Death		- 1	. County of Deatl Baltimor			
Funeral Director	5. Social Security Number 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		If Under 1 Year Months Days		8. Date of Bir Feb. 4	th	g. Birt	nplace (State of	or Foreign	
aryland la-f show ffied at	Usual Residence of Decedent 10a. State	ty, Town or Loca	ition Essex					10d. Inside C	ity Limits	
leath with the Maryland items 23a or 28a-f she ner must be notified at Funeral Director	10e. Street and Number 1004 N. Marlyn Avenue		10f. Zip Code 212 2	 !1		10g. Citizen of What Country? USA				
° - 9 -	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced 12. Was Decedent Ever in U.S Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates.	1	as Decedent of Hi res, specify Cuba	ispanic Origin? (Spe n, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)		14. Race - Amer Black, White Specify: W			
21215-0036 ithin 72 hours after tiene. If than "natural", or the Medical Exami	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	(Give kir life. DO	nt's Usual Occup nd of work done o NOT use retired) hanic	ation during most of workir	ng		ind of Business I	-		
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. mportant: If item 27 is marked other than "natural", o my injury or other traumatic event, the Medical Exam proce. To Be Completed by	17. Father's Name (First, Middle, Last) Richard J. Merryman			18. Mother's Name						
Mary and 2 shoul lealth and P m 27 is ma her traums	19a. Informant's Name/Relationship (Type, Print) Jamie Merryman—daughter			and Number or Rura n Avenue-						
Itimore It. Page 1 a rtment of F rtant: If ite	1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State		tory or other place all Chapel rvices Re	and Aug. 1	7, 2010		rest Hil		land	
Bal permi Depar Impor any ir	21. Signature of Funeral Service Licensee Lindrale L. M. Fuddum	22.1 Ev	Name and Address ans Fune 00 Harfo	eral Chape ord Road-F	l and (rem	ation Se	ryjses		
Physician/ Medical	23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence)	21 y 2 010	Approximate Interval Between Onset and Death							
Examiner อั	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequ	,								
ate be executed bysician and the burial-transit dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or ilinjury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):									
760 cate be exphysician s the buria	d	-								
ox 6 ath cer attend for use	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnant 1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	2 ☐ Fetal death 3 ☐ Ectopic pregnancy at time of death 5 ☐ Other (specify) Mo							Date of delivery Month Day Year	
ords, P.O. B.	Part II. Other significant conditions contributing to death but not result for perleusion Hyperleusion		ite to the cause of death?							
Vital Records, P. hysician: The law requires the his certificate has been signed if director, page 2 should be de To Be Completed by		24b. Were auto prior to co death? 1 \square Yes	mpletion of c	vailable ause of						
Vital ysician: nis certiful director. To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 Inpatient 2	ER/Outpatient	Othe	r: 4 Nursing Hon		ence s	Other (Specif	4)		
ivision of V or Attending Phys after death. Director: After this in by the funeral di		28b. Time of injury	28c. Injury work?	at 2	8d. Describe ho			7		
Division o the Hospital or Attending within 24 hours after death. To the Funeral Director: After completed filled in by the funer Medical Certificate	4 Homicide determined 28e. Place of Injury - At hor building, etc. (Specify))			City or Town	n, State)			er,	
o the Hospita ithin 24 hours o the Funeral ompleted filler Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination 3 Certifying Nurse Practioner: To the best of my 29b. Signature and title of certifier	n and/or investiga	ition in my opinior	n, death occurred at t time, date and place	he time, date ar , and due to the	nd place, cause(s)	and due to the ca and manner as s	use(s) and mai ated.	nner stated.	
		232) (Time Pri		D241 304 B	166	08	e signed (Month,	010		
4+1	724 Marden Choice	Lane	Ste 3	304 B	altin	ore	Med Z	122	8	
State Registrar	37 Aug 18 2000 AUG 18 2000	Ber	4							
DHMH 17 Rev 7/2009		RIGINAL					-			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. No 20 25809 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MARY LOUISE MARSHALL p^M August 2010 1:50 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town or Location of Death 4c. County of Death Examiner 717 Maiden Choice Lane Catonsville Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Year) Months Days 1 □ M 2 🗓 🟋 Hours 232-26-8658 Director 88 12/25/1921 West Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, if the Medical Eventines must be some 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 □ No XX Director Maryland Baltimore Catonsville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 717 Maiden Choice Lane 21223 Funeral U.S.A. 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2KKNo δ Specify Specify: 3 XVidowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Grade 12 College (1-4or 5+) Analyst Dept. of Defense 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Russell V. Ridenour ٥ Genevieve Bowmaster 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arthur Russell 8903 Eastbourne Lane Laurel, Mayrland 20708 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 **KK** remation 3 ☐ Removal from State W. Arundel Crematory 8/18/2010 4 □ Donation 5 □ Other (Specify) Odenton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Avenue Laurel, M00770 Maryland 20707 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) cancer months una /Medical Due to (or sa onsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Irigiry that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): P.O. Box 68760, sate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ۾ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No certificate 2 No 1 ☐ Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation death. 1 □Yes 2 □ No after death completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P 30989 30. Name and add erson who completed cause of death (Item 23a) (Type, Print) Maiden Choice Ln Aponter h, Day, Year) MD iled (Month, Day, State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No.20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Mary G. Medford nuqust Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death **Examiner** Burnie Glen Baltimore Washin nne If Under 1 Year If Under 24 Hrs 8. Date of Birth 9 Birthplace (State or Foreign **Funeral** (Month, Day, Year) 08/15/1918 1 🗆 M 2 🗓 F Days Min. Maryland Months 91 Director 212 09 8454 Usual Residence of Decedent 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No Maryland Anne Arundel Glen Burnie 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code Funeral 201 Crain Highway N. Apt. D 21061 U.S.A. or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No If Yes, Give Black, White, etc. 1 Never Married 2 Married ò 1 ☐ Yes 2 X No Specify MEDFORD, MAR Hygiene. other than "natural", 3 🛚 Widowed 4 🗆 Divorced Completed White Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Seconday (0-12) College (1-4 or 5+) Homemaker Own Home and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Charles Dawalt Nellie Schillinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a :: If item 27 is 568 East Avenue J. Unit A Grand Praire, Texas 75050 Charles Medford / Son injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or 08/16/2010 Glen Burnie, Maryland 4 Donation 5 Other (Specify) Glen Haven Mem. Park . Signature of Funeral Service Lies 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Dear Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) physician and the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death the detached 9 Unknown 9 Unknown n signed by t Id be detach Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Disease 2 No 1 Tes 3 Probably 4 Unknown completed filled in by the funeral director, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an as autopsy performed After this certificate 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Inpatient 2 ER/Outpatient 3 DOA ည 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 Natural 5 Pending 2 🗌 No Accident Investigation after death 6 🗆 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

Hospital or Attending Physician: The law requires 24 hours a the within To the

State Registrar only one)

AUG 182010

cause of death (Item 23a) (Type, Print) Dr. Ste 305, Glen Burnie MD 21061

DHMH 17 Rev 7/2009

Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. end #19a Per FH G906 8/26/10 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2010 25811 Certificate of Death Decedent's Name (First, Middle, Last) 3. Time of Death $342a_{M}$ 2. Date of Death Physician/ Vixon Medical 4a. Facility Name (if not institution, give street and number) **Examiner** City, Town, or Location of Death County of Death Baltimore maryland Greneral Dital 5. Social Security 220 96 ast birthday) If Under 24 Hrs. 8 Page of Birth 9. Birthplace (State or Foreign 7. Age (In y **Funeral** 1 M 2 G F Months Days Hours Min. Director Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits by Funeral Director MD Baltimore 1 Yes 2 No Street and Number 10e. St 10f. Zip Code 10g. Citizen of What Country? 21217 ISA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? White, etc 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No ack Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working if d. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1 4/or 5+) Worker Be Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) ည anice PAN 19a. In Panice #11111500 Rfre/mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 10, BOX 82 Kingsville 21087 MD 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State dallstown, 4 ☐ Donation / ☐ Other (Specify) 21. Signature of 23a. Part 1. F te (he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock / reart failure. List only one cause on each line.

Immediate G use (Final disease of condition and conditi Approximate Interval Between Onset and Death Physician/ d'sease Attenoscler Medical resulting in death) Due to (or as a consequence of) Examiner morbid Sequentially list conditions, Examiner cause (Disease or iinjury that initiated events Ducito for as a consequence of: attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? ate has been signed by the atte page 2 should be detached for Month Day Year Pregnant at time of death Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death

1 Whatural
2 Accident Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending work? 2 🗍 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 116/10 mer-0 0031865 mp 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Miren Door Kroupe, M.D. 821 N. (N. Entaro St. Surte 206 Balto., md. 2120/ 32. Registrates Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State	State of Marylan				ınd Mei	ntal Hyg	iene	10	250	10
		Registrar 1. Decedent's Name (First, Middle, Last	-	Cer	tificate of L	Death			9, 110,	10	258	
Physici Med		WALTER CORNELIU		JR				Date of Deatl Month UGUST	16, Day 201	0 ^{Year}	3. Time of Dea 2:40P	eath M
Exami	ner	4a. Facility Name (if not institution, give s 6109 Bellinham Cou	•		4b. City, Town, or Baltim		Death		4c. County of Death Baltimore			
Funera Directo		5. Social Security Number 6. Sec. 1216-24-8187	7. Age (In yrs, Ia	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours		Date of Birth	327		place (State or Fo	oreign
and show at	'n	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Loc	eation					1	0d. Inside City Li	imits
e Maryle r 28a-f notified	Direct	Maryland Baltimor	е Ва				1 🗌 Yes 💸 🗓	⋈ (X				
n with th is 23a o	Funeral Director	6109 Bellinham Cou	rt #1122		10f. Zip Code 21210)		1	0g. Citizen of V US		try?	
ire, Maryland 21215-0036 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 □ Never Married ※ MX Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1XX Yes 2 □ No WI If Yes, Give Year or Dates.	AF I I I	Vas Decedent of Hi Yes, specify Cuba		in? (Specify Puerto Rica	Yes or No- an, etc.)		e - Americ k, White, e		
72 hour	Completed	15. Decedent's Education (Specify only highest grade completed) [Give kind of work done during most of working life. DO NOT use retired) [Give kind of work done during most of working life. DO NOT use retired)								nd of Business Industry		
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", o traumatic event, the Medical Exam	Be Col	Elementary/Seconday (0-12) 17. Father's Name (First, Middle, Last)	College (1-4 or 5+) 4col	Real	•				Real		.e	
ylance III be file Mental I larked o atic eve	P	Walter Cornelius Pohlhaus Sr Dorothy Robertson										
'e, Mar and 2 shou Health and tem 27 is m		19a. Informant's Name/Relationship (Type Jeannie Downs Pohl		19b. Mailin 6109	g Address (Street a Bellinham	and Number	or Rural Ro	ute Number (22 Ball	city or Town, Si Limore,	tate, Zip C Mary	land 21	210
		20a. Method of Disposition ☐ Burial 2XX Cremation 3 ☐ F ☐ Donation 5 ☐ Other (Specify)	Removal from State Gree	emetery, crem enMount	sition (Name of eatory or other place Cremato	ry \$8,		010 Ba	20c. Location - altimor	e, Ma	ryland	
Baltimo	,	2). signature of Funeral Salvice Licensa	on Kena	Cis 22.	Name and Address				efeld Fre, Mar			Inc
Pnysician	<i>'</i>	23a. Part 1. Enter the disease or compl shock, or heart failure. List only one Immediate Cause (Final disease or condition	ications that caused the death e cause on each line.		the mode of dying		ardiac or res	spiratory arres	t,		Approximate Interval Betweer Onset and Deatl	
Medical Examiner	L	resulting in death)				7						
uted d ansit	amine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to (or as a consequ	erice oi).						5.0		
ate be executed ohysician and the burial-transit	dical Examiner	resulting in death) Last	Due to (or as a consequent	ence of):								
68 /6 certificate nding phy ise as the	I do	IF FCMALE.										
Geath of atter	Physician/M	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregnar 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown	death 3 🗌	Ectopic pregnancy Other (specify)	у			23d. Date Mor	e of delive oth	ry Day Year	
IS, P.O. Lires that the signed by all be detached.	\$	Part II. Other significant conditions con	ntributing to death but not resu	ilting in the ur	derlying cause giv	en in Part I.					e cause of death	
VITAI KECOFGS, ysician: The law requires is certificate has been sig director, page 2 should b	Completed							24a. Was an autopsy perform	р	/ere autop rior to con eath?	sy findings availa npletion of cause	able e of
iii Th	ပို	25. Was case referred to medical			26 Pla	ice of Death	(Chook anh	1 ☐ Yes 2	No 1	☐ Yes	2 □ No	-
VITC ysicia s cert direct	To Be	evaminer?	ospital:	B/Outpatient	Otho			1.	ice 6 🗌 Other	(Cassiful		
ding Phy th. After thi		27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident Investigation		28b. Time of injury	28c. Injury work?	at	28d.	7	/ injury occurre			
JIVISION OT al or Attending Ph s after death. I Director: After th d in by the funeral	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, stree			28f. I	Location (Stre City or Town,	et and Number State)	r or Rural I	Route Number,	
DIVISION OF VITAL RECORDS, P.O. In the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director. After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	Medical	Check 2 □ Medical Examine	cian: To the best of my knowled pr: On the basis of examination Practioner: To the best of my	and/or investig	gation, in my opinior	n, death occu	urred at the t	time, date and	place, and due	to the caus	se(s) and manner	stated.
To t with To th		29b. Signature and title of certifier	~~		29c. License		303		d. Date signed	(Month, D	ay, Year)	2
		30. Name and address of person who con	mpleted cause of death (Item	23a) (Type, Pr	10701 N-	Cha	rh	ST	tous	× 1	no	
Sta · Registr		31. Date filed (Month, Day, Year) AUG 18 2010	32. Registrar's Signatu	ire de la companya de								

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 25813 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 Year John W. Pierson, Jr. August 8:40 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death **Baltimore** Gilchrist Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 🛛 M 2 🗆 F Days Months Feb 06, 1923 Director 219-16-1678 87 Maryland Usual Residence of Decedent permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Baltimore Baltimore Md. 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21220 1902 Wilson Pt. Rd. USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Divorced 4 Divorced Specify Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Insurance Agent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Caroline Weigand John W. Pierson, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1902 Wilson Point Rd. Baltimore, Md. 21220 Mrs. Margaret Pierson/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Hilltop Service Co. 8-17-10 4 ☐ Donation 5 ☐ Other (Specify) Towson, Md. 21. Signature of Funeral S. 22. Name and Address of Towson Funeral Home, 1050 York Rd. Towson, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of; cause. Enter Underlying Examir attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Day Pregnant at time of death Year signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed plnous Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.
2 hours after death.
Promeral Director: After this certificate has learners. autopsy 2 No 1 Yes Yes 2 4 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 Other: မ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury 1 Natural 5 Pending 1 ☐ Yes Accident 2 🗆 No completed filled in by the Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar (Check only one)

29b. Signature and title of certifier

AUG 18

(Mghth, Day, Year,

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Division of Vital Records, P.O. Box 68760

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d, Date signed (Month, Dav. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25814 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Josephine C. Rye 08 - 14-20 Pg 0405 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Harford Bel Air Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Months Hours 08 M27 - Pro 39 82 Director 213-36-7135 MD Usual Residence of Decedent or 28a-f show a notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Harford Darlington 1 Tes 2 No 10e. Street and Number 10g. Citizen of What Country? ò 10f. Zip Code ·1 and 2 should be filed within 72 hours after death with the of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be a Funeral 4104 Conowingo Rd 21034 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. \$ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 M No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph Bruno Mary Livolsi permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bobby Rye (wife) 4104 Conowingo Rd Darlington, MD 21034 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Bayview Crematory 08-17-2010 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatury 22. Name and Address of Facility Schimunek Funeral Home of BelAir Inc 610 W. MacPhail Rd BelAir, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Severe Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Preumonia Sequentially list conditions, if any leading cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence of the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: for use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year ☐ Pregnam ☐ Unknown 1 ☐ Yes 2 ₺ 9 ☐ Unknown **Director:** After this certificate has been signed by the it in by the funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by cancer with brain metastalis 1 Yes 2 No 3 Probably 4 Unknown Acute renal failure 24b. Were autopsy findings available prior to completion of cause of death? performed? Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: Certificate: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 1 Watural 5 Pending work? 2 Accident
3 Suicide
4 Homicide Investigation 1 Yes 2 No within 24 hours after der To the Funeral Director completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practionar T. the basis of my knowledge, death occurred at the time, Jate and place, and due to the cause(s) and manner as elated. 29a. Certifier (Check 29b. Signature and title of certifier 29c. License number D63420 AUGUST 14, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Z 500 upper Chesapeake Dr Bel Air MD 21014 Kharal 31. Date filed (Month, Day, Year) 42. Registrar's Signature

State Registrar

TOD 0405

14/10

N800426940

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 25815 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician AUGUST 2010 MARGARET WILMA ROLLMAN 9:00 P.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner AUGSBURG LUTHERAN HOME MILLFORD MILL BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Months Days Hours Min 1 □ M 2 🛛 F 215-09-6679 Director 100 5/4/1910 MARYLAND Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, its Modical Examinant must be notified at 10a. State Director 1 ☐ Yes 2 No BALTIMORE MD MILFORD MILL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6811 CAMPFIELD ROAD 21207 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Yo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Ω. Specify: WHITE 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) LAW FIRM BOOKKEEPER 12TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MARGARET A. WITGREFE ೭ ERNEST W. BERGER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GLORIA BARNSTORF/ATTORNEY 5229 6TH STREET BALTIMORE, MD 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) IMMANUEL LUTHERAN CH. 8/19/2010 BALTIMORE, MD 22. Name and A Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee MCO217 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duvi to (or as a consequence of) executed Exami and burial-tra Due to (or as a consequence of) O. Box 68760, attending physician for use as the buria The law requires that the death certificate be Physician/Medical as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) the 9 Unknown detached 9 Unknown signed by t σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Š 2 🗌 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy this certificate 2 1 No 1 □Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ 2 ER/Outpatient 3 DOA 1 Inpatient After thi funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1, Natural 5 Pending investigation 1 ☐ Yes within 24 hours after death

To the Funeral Director: completely filled in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) suelle nu SMITH AVE SUITE 213, BALDMI) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MM 2835 ASNETM teami, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 25816

		1- For State Certificate of Death		Re	g. No.	20010			
Physic M≏dical Exam		Decedent's Name (First, Middle,Last) NANCY C. RUARK	h Day Year , 2010	3. Time of Death 1525 hrs					
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or	r Location of Deat		4c. County of Death				
Funeral		4 Morrislea Court Parkville 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yes	ar If Under 24Hr	s 8 Date of Birt	Baltimore Cou				
Director		213-30-0022 1 M 2 F 78 Yrs. Months Day	Foreig						
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			-	10d. Inside City Limits			
Maryland 28a-f show d at once.	5	MD BALTIMORE PARKVIL	LE			1 Yes 2 X No			
Maryl r 28a-1 ed at o	Director	10e. Street and Number 10f. Zip Code	100/	10	g. Citizen of What Cou	ntry?			
with the Maryland ns 23a or 28a-f sho be notified at once.		4 MORRISLEA COURT 2 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hi	1234	Precify Yes or No.	USA	can Indian, Black,			
or iter	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cubar 3 Widowed 4 Divorced If Yes, Give Year If Yes 2 No	n, Mexican, Puert		White, etc.	WHITE			
ours afi atural'	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupa	lates:						
72 ho n 72 ho nan "na ical Es	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	,						
-003 d withi giene. ther the	mo	12th GRADE SALES REPRES. 17. Father's Name (First, Middle, Last)		e (First, Middle, M	AVON				
21215-0036 hould be filed within 72 hours after ad Mental Hygiene, "natural", it is marked other than "natural", itic event, the Medical Examiner	Be	H. ROLAND RUARK	MERGEHENN						
ore, MD 21215-003(gs 1 and 2 should be filed within of feath and Mental Hygiene. If item 27 is marked other tha ther traumatic event, the Media	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street			-				
and 2 sho Tealth and item 27 is		HENRY R. RUARK/BROTHER 403 ALABAMA 20a. Method of Disposition 20b. Place of Disposition (Name of ce	emetery,	Date	RYLAND 2120 20c. Location - City or	O4 Town, State			
Baltimore, MD 2' permit. Pages I and 2 should Department of Health and M Important: If riem 27 is minjury or other traumatic e		1 XBurial 2 Cremation 3 Removal from State LORRATINE PARKED CEM 4 Defiation 5 Other, Specify:	. 8	/18/2010	WOODLAWI	N, MD			
taltin rmit. I spartm uporta jury ou	1	21. Signature of Fuperal Senice Licensee 22. Name and Address	s of Facility T	HĒ JOHNS	ON FUNERAL	HOME P.A.			
	. (3 a.l. Enter the isease, or implications that caused the death. Do not enter the mode of dying,			WSON, MD 2				
Physician /Medical		failure. List only one cause on each line.	, such as cardiac i	or respiratory arre	st, snock, or neart	Approximate Interval Between Onset and Death			
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Head and Neck Injuries Due to (or as a consequence of):				-			
	-a	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):							
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated							
uted nd ransit	_	events resulting in death) Last Due to (or as a consequence of): d.							
760, frate be executed physician and the burial - transit	Medica	UNPENDED AMENDED	·						
3760, ificate be g physic s the buri		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	23d. Date of delivery						
Box 687 death certificate attending	icia	past 12 months? 1	Ectopic pregna	aricy	Month	ay Year			
D.O. BC that the dea ned by the a detached fo	Physician/	Part II. Other significant conditions contributing to death but not resulting in the underlying cause of	niven in Part I	23e Did tob	acco use contribute to	the cause of death?			
ires that the signed by	Ď	contributing to document to the larger of the second of th	giveiriir aiti.		2 No 3 Prob				
rds, requir	letec			24a. Was ar		topsy findings available ompletion of cause of			
Reco	Completed			perform	ned? death?	_			
of Vital Records, ng Physician: The law require ther this certificate has been si meral director, page 2 should be	Be		of Death (Check						
of Vi ing Physi After this tuneral dir	ျ	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury	Other Nursing		tesidence 6 🗸 Other	Scene			
OD C ending sath. or: Af the fun	Certification:	1 Natural 5 Pending Aug 14, 2010 1500 hrs 1	Yes 2 V No	Probable fall					
Division tal or Attendir rs after death. al Director: A led in by the fu	tifica	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office b	ouilding, etc.	28f. Location (St or Town, Sta	reet and Number or Rui	al Route Number, City			
Ospital bours uneral y fillec		4 Homicide determined (Specify) Single Family 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, de		4 Morrislea Cou	urt, Parkville, MD				
Division of Vital Records, P.O. Box 68760, To the Bospital or Attending Physician: The law requires that the death certificate be executed within 24 hours and extendent. To the Funeral Direct After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion							
Ž ½ ½ Š	Be	and manner stated. 29b. Signature and title of certifier 29c. License	e number		29d. Date signed (Mon	th, Day, Year)			
		family outhall, m) O.C.	M.E.		August 15, 2010				
ļ		Name and a dress of poson who completed cause of death (Item 23a) Pamela E. Southall, MD	t. Baltimore M	MD 21201					
St	ate	31. Date filed (Month, Day Year) 32. Registrar Signature	-, - = = = = = = = = = = = = = = = = = =						
Regist	rar	AUG 18 2010 Chur B. Marce			OCME				
					COME				

10-06089 Steven James Schaufert Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2010 25817

		Registrar		Cerui	icate of	Deam				Reg. No.			
Physic Medical Exan			s Schaufer			Date of Dea Month August 1	Day Yea	3. Time of Death 1020 hrs					
		4a. Facility Name (if not institution 4719 Shelltown Road				4b. City, Town, o	ation	f Death		4c. County of Death Somerset			
Funera Directo		5. Social Security Number 214-68-7421		ge (In yrs. last i	birthday) Yrs	If Under 1 Ye Months Da		24Hrs. Min.		1 1 9 5 7	9. Birthplace (State or Foreign MD		
Maryland 28a-f show any d at once.	ctor	Usual Residence of Decedent 10a. State 10b. County MD Some: 10e. Street and Number	rset	10c. City, Tov		on Station	1			10g. Citizen of Wh	10d. Inside City Limits 1 Yes 2 X No		
th the Ma 23a or 28	I Director	4719 Shell	town Road			21838	3			ÜSA	at Courtily?		
3, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland fealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23s or 28s-f shoo traumatic event, the Medical Examiner must be notified at once.	d by Funeral	11. Marital Status 1 Never Married 2 M 3 Widowed 4 Div 15. Decedent's Education (Spe	orced If Yes, Give Year	? X _{No}	1 1 a. Deceden	s Decedent of Hes, specify Cuba Yes 2 No. No.	an, Mexican, For specify: ation (Give king)	Puerto Ri	can, etc.)	White	White		
0036 within 72 hagiene. her than "n.	Completed	Elementary/Secondary (0-12)	College (1-4 or	5+)	during mo Emplo	ost of working life					Deere, Inc.		
21215-0036 uild be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be C	17. Father's Name (First, Middle, Richard Jame	es Schaufe		101 111		Kathe	erin	e Lou	Maiden Surname) lise Ste			
e, MD 2 1 and 2 shou Health and N Fitem 27 is n	2	19a. Informant's Name/Relations Edward P. So			2664	2 Mari	ners	Rd.	,Cris	-	MD 21817		
imore Pages 1 ment of F tant: If i	1 Burial 2 Arremation 3 Removal from State crematory or other place)										Glen Burnie, MD		
											Main St. eld,MD 21817		
Physician /Medical Examiner		failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line. Ather	oscler perther	otic (e mode of dying Cardiova	ascula	r Di	espiratory arm	est, shock, or hear Complica	Approximate Interval Between Onset and Death		
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause											
tted of i	Examiner	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conse	equence of):				-					
760, cate be execut	an/Medical	X UNPENDED				er me g	907 9-	16-1	0 vt				
rtifi as t	Physician/M	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1								elivery Day Year			
ires that the signed by the be detached	ð	1 Vac 2 Mag 3 Probab											
Division of Vital Records, P.O. Box 6 To the Hospital or Attending Physician: The law requires that the death ce within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attend	Completed						_	- 17	24a. Was a autope perfor 1 ✓ Yes	sy pri med? de	ere autopsy findings available or to completion of cause of ath? Yes 2 No		
Vital Rechysician: The this certificate director, page	Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatie	nt 2 FR/0	Outpatient		of Death (Cl			Residence 6	Other Scane		
1 of \ding Phy.	on: To	27. Manner of Death	28a. Date of Inju	y 28b.	. Time of Inj	ury 28c. Inju	ry at Work?	280		now injury occurred			
risior r Attender death rrector:	ficati	2 X Accident Invest	tigation 28e Place of Ini		10:00 farm, street	Jam	Yes 2 X No	e	Ellocation (S	troot and Number	environment or Rural Route Number, City		
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	Certification:	4 Homicide determ	mined (Specify)	house	е			Ma	or Town, Starion	state) 4719 Station,	Shelltown Rd. Md.		
o the Horitin 24 o the Fu	Medical	(Check only	ysician: To the best of my niner:On the basis of exan and manner stated.	knowledge, de nination and/or	eath occurre investigation	ed at the time, da on, in my opinion	ate and place , death occur	e, and due rred at the	e to the cause e time, date a	e(s) and manner a and place, and due	s stated. e to the cause(s)		
E 3 E 8	Me	29b. Signature and title of certifier				29c, Licens					(Month, Day, Year)		
الم		30. Name and address of person v	Moule who completed cause of de	eath (Item 23a)		O.C.I	VI.Ŀ. 			August 15, 2	010		
φ		Margarita Korell MD.	Assistant Medical	Examiner		nn Street, Ba	altimore, M	MD 212	201				
St Regist		31. Date filed (Month, Day, Year)	32. Registrar	s Signature	Mal								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	Amend	Item	State of M 26 per	aryland verb. ,	/ Depa g906 <i>Cer</i>	rtment of l 08/18/2 tificate of l	Health 010df Death	and Me	ental Hy	giene Reg. N	2010	25	818
Physicia Medi		1. Beographics Name	e (First, Middle	e, Last)	Stac	Ger	5-7	owell	,	1	2. Date of De		ay		of Death
Examir		4a. Facility Name (ii	1311	5/1/0	,	a) al		4b. Clay, Town, o	or Location	of Death	n	40	County of De	ath .	
Funeral Director		5. Social Security N		6. Sex	- 170	e (In yrs. last I	birthday) Yrs.	If Under 1 Year Months Days	If Unde Hours	r 24 Hrs. 8	B. Date of Bir (Month, Da		9. B	irthplace (State	e or Foreign
yland f show ed at	żōr	Usual Residence of 10a. State	Decedent 10b. County	,		10c. City, To	own or Loc	ation						10d. Inside	City Limits
the Mar or 28a- e notifie	Funeral Director	10e. Street and Nur	134 /	tim	ore	GW	Ynn	Oa K				10a C	itizen of What C		Yes 2 No
ith with ms 23a must b	inera	6 Cris	mer	C	ourt				207	7		.og. o	U5A)	
Yland 21215-0036 Id be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or items 23a or 28a-f sho afte event, the Medical Examiner must be notified at	亥	11. Marital Status 1 ☐ Never Marr 3 ☐ Widowed		ried	Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates.		If	as Decedent of H Yes, specify Cuba	an Mexica	n, Puerto Rio	y Yes or No- can, etc.)		14. Race - Am Black, Whi		
215-0036 in 72 hours after e. nan "natural", o Medical Exam	Completed		15. Deceder	est grade c	ompleted)	17	(Give ki	ent's Usual Occup nd of work done o NOT use retired)	durina mos	st of working		16b. k	(ind of Business	Industry	
d 212 ed withir Hygiene Wher tha	Be Co	Elementary/Secondary 17, Father's Name (i			College (1-4 or 5	+) /	Penta	1 Heal	the	Nork	er	H	ealth	care	2
yland	10	Willia	m S	tag	gers				18. Moth	er's Name (F	First, Middle,	Maiden <u>4</u> 5	Surname)		
NORE, MARYIE ge 1 and 2 should by the fleatth and Mer if item 27 is marke or other traumatic		19a. Informant's Na	me/Relationsh	1	ridi ers/Br	Hor	9b. Mailing	Address (Street	and Numb	er or Rural R	oute Numbe	r, City oi	Town, State, Z	ip Code)	1/2/17
Baltimore, bennit. Page 1 and Department of Heal Important: If item 2 any injury or other		20a. Method of Disp	☐ Cremation	3 ☐ Rem	oval from State	20b. Place	of Disposi	tion (Name of tory or other place		Dat		20c. L	ocation - City o	Town, State	100/
baltim permit. Pag Departmen Important: any injury once.		4 Donation 21. Signature of Fur				1/1	10 22.	Name and Addres	ss of Facili		2010 n.C.C.	100	ne Fune	palse	nl)
		23a. Part 1. Enter ti	ne disease, or	complicati	hure ons that caused	the death. Do	o not enter	7 28 L/b.	g, such as		Randa espiratory arr		town, m) 2//3 Approxim	
Physician/ Medical		Immediate Cause (I disease or condition resulting in death)	Final	nly one ca	use on each line.	Pres	emo	ne						Interval B Onset an	etween
Examiner	_	Sequentially list cor	nditions.	Г b	Due to (or as a	consequence	shi							1 mas	M
uted id ansit	Examiner	if any, leading to im cause. Enter Under Cause (Disease or i that initiated events	mediate lying injury	_	Due to (or as a	consequence	e of):								,
r ov cate be executed physician and s the burial-transit	edical Ex	resulting in death) L			Due to (or as a	consequence	e of):						-		
		IF FEMALE:		d											
To the Hospital or Attending Physician: The law requires that the death certifics within 24 hours after death certificate the Funeral Director. After this certificate has been signed by the attending p completed filled in by the funeral director, page 2 should be detached for use as to	Physician/N	23b. Was decedent j in the past 12 m 1 ☐ Yes 2 ☐ 9 ☐ Unknown	onths?	1 4	f yes, outcome o Live Birth 2 Pregnant at Unknown	Petal dea	ath 3 🗌 (Ectopic pregnancy Other <i>(specify)</i>	у				23d. Date of de Month	livery Day	Year
ires that the signed by do be deta	^	Part II. Other s ig ni fi	cant conditio	ns contribu	iting to death bu	t not resulting	g in the unc	lerlying cause give	en in Part I	i.			se contribute to		
w requir	Completed			der v							1 🗆 Y 24a. Was a	ın	24b. Were au	robably 4 topsy findings	available
n: The la ficate harry, page		25. Was case referred	d to modical										death?	completion of	cause of
hysicia his certi	일 일	examiner?		Hospit		nt 2 🗆 ER/C	Outpatient	Othe		th (Check on		ence 6	X Other (Spec	Assis	ted
ath. r: After t	Certificate:	27. Manner of Death 1 Matural 2 Accident	5 Pending		Ba. Date of injury (Month, Day,		Time of injury	28c. Injury work? M 1 🗆	at	28d	. Describe ho			-7/ 1.1 V 111	8
al or Atte s after de I Directo d in by th		3 ☐ Suicide 4 ☐ Homicide	6 Could n	ot be	Be. Place of Injury building, etc.	y - At home, f (Specify)	farm, street	, factory, office		28f.	Location (St City or Town		l Number or Ru	ral Route Nun	nber,
Hospita 24 hours Funeral eted fille	Medical	(Uneck 2)	— Medical Ex	:aminer: O	n the hasis of exa	mination and	or investiga	ured at the time, ation, in my opinion	n death oc	curred at the	time date an	d place	and due to the	anion(a) and a	anner stated.
To the within To the compl		only one) 3 L	_ Certifying i										and manner as e signed (Month	stated.	
	3	30. Name and addres	ss of person w	ho comple	ted cause of dea	ath (Item 23a)	(Type, Prin	29c. License D2 II)	5040	1		8/	716/10		
State		1. Date filed (Month,	10010	mon	32 Registrar's	27/7	the	m mance	6/	eny	Rd		212	2)	
Registra		Α	UG 18	2010	Deven	J B.	190	No.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Vear BIZG PM 2010 Medical 4a. Facility Name (if not institution, give street and Battmare Examiner 4c. County of Death DMMUN If Under 1 Year If Under 24 Hrs. 8. Date of Birth S(Month, Day, 9. Birthplace (State or Foreign Funeral 1 M M 2 🗆 F Min Yrs. Director 28a-f show 10d. Inside City Limits at 10a, State 10b. County 10c. City, Town or Location Director ral", or items 23a or 28a-f s Examiner must be notified 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married Yes Give Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: 3 XWidowed 4 ☐ Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Son) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town. State Date cemetery, crematory or other place injury or 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) o Funeral Service Licensee 22. Name and Address of Facility To Rus 23a. Part 1. Inter the disease, occomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate any. Ent. I linguistic Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): bunial-transit and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death signed by the a d be detached f Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾| 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen: 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy death? 2 🗆 No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 X No 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence To the Funeral Director: After this completed filled in by the funeral dil 27. Manner of Death 1 Natural 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 5 Pending 2 🗆 No after death. Accident
Suicide nvestigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ly on 29d. Date signed (Month, Day, Year) 2010 o completed cause of death (Item 23a) (Type, Print) 3900 aven Bou

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month HELEN D. SIGWART /Medical ugust 2010 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death timore Square Franklin

5. Social Security Number Age (In vrs. last birthday) **Funeral** 8. Date of Birth 1 □ M 2**X**□ F Months Days Hours Min. 086-16-8087 89 Director April 29,1921 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show r than "natural", or items 23a or 28a-f shov the Medical Examinar nast be notified at 1 □Yes 2XXNo Maryland Baltimore Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4300 Cardwell Ave. Apt. 116 21236 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ②CNNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Signart Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 🖫 No Specify: Specify: White 3√Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 8 yrs. N/A Homemaking-Own Home 7 Is marked other traumatic event, ■ 17, Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Andrew Dzierwinski Mary Maniowczyk 2 permit. Pages 1 and 2 should Department of Health and Me Important: If them 27 Is mark any injury or other traumationce. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul L. Sigwart (Son) 4212 Cardwell Avenue Nottingham, Md. 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State XI Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 8-20-2010 Baltimore, Md. 22. Name and Address of Facility Lassahn Funeral 7401 Belair Rd. 21. Signature of Euneral Service Lice F. 8. Home Baltimore 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician accinomo 50 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day signed by the a d be detached for 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physiclan: 'within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ၉ 1 ☐ Yes 2\17\No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ~ 063054 ust 16, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Majid E. Cina, 9000 Franklin Square Drive, Baltimore 21237 MD,

State Registrar 31. Date filed (Month, Day, Year)

UG 182010

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25821 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year 4:00 AM Evelyn Marie Seechuk 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Health & Rehabilitation Harford 9. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** 1 □ M 2 🗓 F Months Days Hours 214-20-9964 Director 12/29/1916 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County show 10d. Inside City Limits 'natural", or items 23a or 28a-f shov dical Examiner must be notified at Director 1 ☐ Yes 2 No MD Baltimore Kingsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2512 Longview Drive Funeral 21087 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify Specify: White þ 3K Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Seechuk Delicatessen Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wn Department of Health and Mental Hygien. Important: If Item 27 is marked other that any Injury or other traumatic energy. and Grocery 12 Self-Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (Unknown) Zeman Katherine(Unknown) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dennis J. Seechuk (son) 2512 Longview Drive - Kingsville, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Most Holy Redeemer 08/23/2010 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 6 11750 Belair Road - Kingsville, Maryland assah 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 12425 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-tran Due to (or as a consequence of): ng physician a as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□Unknown 9 ☐ Unknown Part II. Other/significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performe 1 🗌 Yes the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 21 No Other: 1 🗌 Yes 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

P.O. Box 68760 Records, Vital Hospital or Attending Physician: Division or

be executed

72 hours after

Baltimore, Maryland 21215-0036

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of contifier

DHMH 17 Rev 1/2001

ORIGINAL

pleted cause of death (Item 23a) (Type, Print) 1308

29c. License number

29 Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Dav argare 2010 Medical <u>Jaust</u> Examiner 4a. Facility Name (if not institution, a ve street and number 4b. City, Town, or Location of Death 4c. County of Death ilchrist Center. tospice Itimore DWSC Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 D M 2 X F Days Hours Min. 235-01-8552 G Country Director October 10 Virginic Usual Residence of Decedent 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director WD 1 Tes 2 No Himore ö 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21228 nited states items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or ģ 1 Never Married 2 X Married 1 ☐ Yes If Yes, Giv Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic once, (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) stration Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Burress Edward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21228 laden 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State torest Hill, MD 4 Donation 5 Other (Specify) remation Service 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Evans Funeral Chapel + Cremation
8500 Harford Road Parkuille Parkuille MD 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Deat Physician/ disease or condition resulting in death) Medical Due to for as a consequence of Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury Due to for as a consecuence of Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 as the attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy for Month Pregnant at time of death 5 Other (specify) Day Year detached 9 Unknown Linknown completed filled in by the funeral director, page 2 should be detach Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗆 No 2X No 1 \sum Yes Yes Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No ျှ 1 \sum Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Hatural 5 Pending injury 2 Accident
3 Suicide 1 Yes 2 No safter death Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Xcertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one Signa License number

DHMH 17 Rev 7/2009

State Registrar and address of pe

th (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hospice 10WSO1 paltimor If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🏿 F (Month, Day, Year) Days Months 215-24 Hours Min. Country) Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits notified 28a-f MD altimore 1 Yes 2 No ò 10e, Street and Number 10f. Zip Code ms 23a or must be n 10g. Citizen of What Country? Funeral er than "natural", or items the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. Armed Forces ģ 1 Never Married 2 Married 1 Yes If Yes, Give 2 🗓 No Maryland 21215-0036 1 Yes 2 & No Specify: "natural" Completed 3 Widowed 4 Divorced Specify: white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. d other than " Elementary/Seconday (0-12) College (1-4 or 5+) Hale's Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ပ vans eorge pern it. Page 1 and 2 should be Dep. rtment of Health and Meni Imp. rtant: If item 2r is marke any nijury or other traumatic onc. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sullivan Northbrook ane Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) & Evans Function Services Delair 20a. Method of Disposition Date 20c. Location - City or Town, State 1 \square Burial 2 \blacksquare Cremation 3 \square Removal from State 8-18-2010 Maryland 4 \square Donation 5 \square Other (Specify) Forest Hill, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services 800 Harford Parkoille 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) or as a consequence of **Examiner** Sequentially list conditions, if cause. Enter Underlying Cause (Disease or linjury that initiated events Die to for as a consideration of Examir The law requires that the death certificate be executed and-trar resulting in death) Last Due to (or as a consequence of) burialphysician s the burial Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year ed by the 9 Unknown Unknown P.O. been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? g A Division of Vital Records, 10my overnu 1 ☐ Yes 2 ☐ No 3 🗗 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s performed? Yes 2 No certificate morris mitersion 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Hospital 1 Tyes 2 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home After this 5 Residence 6 DO Other (Specify) filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 \square Homicide determined Hospital Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature stitle of certifier 29d. Date signed (Month, Day, Year) -010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHANKES TOW SON N. Charles 31. Date filed (Month, Day, Year) ar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Joseph Setters 7:12 A.M August 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson Gilchrist Hospice If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days 213-40-4657 1XXM 2 | F (Month, Day, Year) une 3. 1944 Balt. Maryland Director 66 Yrs. June Usual Residence of Decedent 28a-f shov 10a State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location the Medical Examiner must be notified at Director 10d. Inside City Limits Phoenix Maryland Baltimore 1 Yes 2XXNo 5 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? United States items 23a Funeral 13232 Jarrettsville Pike 21131 of America 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ō þ 1 Never Married 2 XMarried Black, White, etc Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 No Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Ilmportant if item 27 is marked other than any injury or other transmets. Elementary/Seconday (0-12) College (1-4 or 5+) Forward Visions Maintenance Supervisor Be 17. Father's Name (First, Middle, Last)

Dewey Setters 18. Mother's Name (First, Middle, Maiden Surname 2 Dorothy Elizabeth Gill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13232 Jarrettsville Pike Phoenix, Maryland 21131 Mrs. Paula J. Setters/ wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State August 15. 1 Burial 2 Cremation 3 Removal from State Evans Function (reflect place) Chapel – Bel Air 4 Donation 5 Other (Specify) Forest Hill, Maryland 2010 21. Signature of Fu e al Service 22. Name and Address of Facility Feaceful Alternatives Funeral & Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Transitional cell concer of urothelia disease or condition Q Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to (or as a consequence or). If a n, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events y physician and as the burial-trans resulting in death) Last Due to (or as a consequence of): Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) in the past 12 months? Day Pregnant at time of death Month signed by the a Yes 2 No g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an The law has autopsy performed? Yes 2 No this certificate 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: thin 24 hours after death. eral Director; After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending injury work? Investigation 1 🗌 Yes 2 🗌 No Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined within 24 hours Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis or examination and/or investigation, in this opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

145356

owsontown

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hydiene

		- Tragional	Ce	ertificate of D	eaith and i Death	vientai Hyt	2010	25825
Physicia Medi		Decedent's Name (First, Middle, Last) Richard Arden St	weringen			2. Date of Dea August	16, Day 2010 Year	3. Time of Death 8:12 A M
Exami		4a. Facility Name (if not institution, give street and number) 70 S. Hawthorne Road		4b. City, Town, or Middle	Location of Death		4c. County of Dea	
Funeral Director		5. Social Security Number 6. Sex 7. Age 1 M 2 F	(In yrs. last birthday,	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt 02/23/1	9. Bir 933 Wes	thplace (State or Foreign
land show d at	ţō	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits
ne Mary or 28a-f notifie	Director	Maryland Baltimore	Middle	River			10. 0	1 🗆 Yes 2 🗶 No
h with the ns 23a const be	Funeral	70 S. Hawthorne Road		21220			10g. Citizen of What Co USA	ountry?
Ind 21215-0036 Filed within 72 hours after death with the Maryland tal Hygiene. Ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by Fu	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 XDivorced 12. Was Decedent Every Armed Forces? 1 Yes, Give Year or Dates.	rer in U.S. 13	Was Decedent of His If Yes, specify Cuban 1 Yes 2 No		ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:	
21215-0036 within 72 hours after giene "natural", o er than "natural", o the Medical Exam	mplet	15. Decedent's Education (Specify only highest grade completed)	(Give	edent's Usual Occupa e kind of work done du DO NOT use retired)	tion uring most of work	ing	16b. Kind of Business	Industry
land 212 be filed within lental Hygiene. ked other thatic event, the N	Be Co	Elementary/Seconday (0-12) College (1-4 or 5+ 12) 17. Father's Name (First, Middle, Last)	·) [ill Wright				elm Steel
Maryland 2 should be filed thh and Mental Hy 27 is marked oth traumatic event	10 E	Charles A. Sweringen			18. Mother's Nam Floda	e (First, Middle, 1 Arler		
		19a. Informant's Name/Relationship (Type, Print) Donald Sweringen (brother)	19b. Mai	ling Address (Street ar 5. Hawthor	nd Number or Run ne Road l	al Route Number Middle F	Çity or Town, State, Zi Liver Maryl	and 21220
Baltimore, permit. Page 1 and Department of Heal Important: If item 2 any injury or other		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	1	ematory or other place)	Date	20c. Location - City or	
Baltimory permit. Page 1:s Department of I Important: If its any injury or of		4 ☐ Donation 5 ☐ Other (Specify) 21. Sig at the of Forecal Service Licensee					Baltimore M Si Funeral 1	
		23a Part 1. Enter the disease, or complications that caused t shock, or heart failure. List only one cause on each line.					sex Maryla	nd 21221 Approximate
Pnysician/	K 16	Immediate Cause (Final disease or Andition		BETE-				Interval Between Onset and Death
Medical Examiner			consequence of):					
ed ssit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	consequence of):					
e execut	al Exa	that initiated events c.	consequence of):		-			
os / ou ertificate b ding physic se as the b	Medical	d						
BOX death c the atten ned for u	by Physician/N	FFEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of in the past 12 months? 1 ☐ Live Birth 2 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9	Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)	,		23d. Date of de Month	ivery Day Year
s that the igned by i		Part II. Other significant conditions contributing to death but			en in Part I.		pacco use contribute to	
ords v require s been s should	Completed	CORONAR	9 213	E1130		1 ⊔ Y	n 24b. Were au	robably 4 Unknown topsy findings available
VICAL MECONDS, Notician: The law requires is certificate has been sig director, page 2 should b	Comp					autops perfor	med? death?	completion of cause of
VICAI ysiclan is certifi director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No 1 ☐ Inpatier	it 2 🗆 ER/Outpatie	Othor	e of Death (Check	, ,	ence 6 Other (Spec	ifu)
n or ding Ph th. After th funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day,		work?	at		w injury occurred	
JIVISION OI al or Attending Pl s after death. il Director: After th ed in by the funeral	Certificate:	3 Suicide 6 Could not be	/ - At home, farm, st (Specify)			28f. Location (St City or Town	reet and Number or Rui , State)	ral Route Number,
e Hospita 124 hours e Funera	Medical	29a. Certifier 1 Certifying Physician: To the best of m (Check only one) 3 Certifying Nurse Practioner: to the best of examiner:	mination and/or inve	stigation, in my opinion	, death occurred at	the time, date an	d place, and due to the	ause(s) and manner stated.
To th withir To th	-	29b. Signature and title of certifier		00-11-				
5x1		30. Name and address of person who completed cause of dea	ith (Item 23a) (Type,	Print)	- 01	0.20	08/16/2	M) 21052
Stat	e	KISHORE WYNDAR 31. Date filed (Month, Day, Year) 32. Registraf	9600 Signardre	NORTH (TI	· KI).	10104	INUM-1,	17 4052
Registra		AUG 18 2010 Deneva 15.	for arke					

10-06024		Please Type or Print in Bl	ack Indelible	Ink. Ens	ure All Cop	oies Are L	.egible.	
Feagan Alex S		1- For State Registrar	/ Department of Certificate of		and Mental		Reg. No.	10 2582
Physic Medical Exam	ian/ iine	TEAGAN ALEX SOMMER					Death Day Yea 11, 2010	3. Time of Death 0955 hrs
		Aa. Facility Name (if not institution, give street and number) 2516 Baurenschmidt Road		4b. City, Town Essex	, or Location of De	eath	4c. County of Baltimor	of Death e County
Funera Director		5. Social Security Number 6. Sex 7. Age 219-87-7228 1 M 2XXF	e (In yrs. last birthday) Y	If Under 1 \ Months E	ays Hours I	Ain	7,2010	9. Birthplace (State or Foreign Country) MD.
with the Maryland ns 23a or 28a-f show any be notified at once.	eral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimore 10e. Street and Number 2516 Baurenschmidt Dr. 11. Marital Status 12. Was Decedent I	Ever in U.S. 13. W	10f. Zip Code 2	1221 Hispanic Origin? (Specify Yes or	10g. Citizen of Wh USA No- 14. Race	10d. Inside City Lim 1 Yes 2 X 1 at Country?
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland eath and Wentel Hygene. cem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Ex miner must be notified at once	Completed by Funeral	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade complementary/Secondary (0-12) College (1-4 or 5	No 1	Yes 2/X I	oan, Mexican, Pue No specify: pation (Give kind of ife, DO NOT use r	of work done	16b. Kind of Bus	White
21215-0036 vald be filed within 72 Mental Hygiene. marked other than 'e event, the Medical	о Ве Сотр	N/A 17. Father's Name (First, Middle, Last) Kevin Thomas Sommer 19a. Informant's Name/Relationship (Type, Print)	<u> </u>	N/A	Anchal	ee Alex	N/A e, Maiden Surname) NaNakorn	
or I in it is it i	ĭ	Joyce E. Sommer (Grandmothe 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:	2516 20b. Place of Dispo crematory or o	Bauern sition (Name of	schmidt cemetery,			
		21. Signature of Funeral Service Licensee	22. I	Name and Addre	ss of Facility Uneral F	lome	/401 Be. Balto.,	Laır Rd. Md. 21236
Physician V/Medical Examiner		23a. Part I. Enter the disease, or complications that caused the failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	explained					t Approximate Interva Between Onset and Death
xecuted n and - transit	I Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the cause of the cause) C. Due to (or as a consequence of the cause) Due to (or as a consequence of the cause)						
	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? AMENDED 23a, 27, 2 23c. If yes, outcome 1 Live birth 4 Pregnant at tir	2 Fe	E g909 .			23d. Date of do	elivery Day Year
P.O. es that the igned by be detach	2	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death b	> Ot	her (Specify) underlying cause	given in Part I.			Ite to the cause of death?
tific pr. p	Be Completed	25. Was case referred to medical		26.Plac	e of Death (Check	1 Yes	psy prio	re autopsy findings available or to completion of cause of the completion of cause of the completion o
f Vitz Physicia er this ce	P	examiner? 1 ✓ Yes 2 No Whospital: 1 Inpatient 27. Manner of Death 28a. Date of Injury	2 ER/Outpatient 28b. Time of Ir	3 DOA	Other Nursi	ng Home 5	Residence 6	
Division of Vita To the Hospiral or Attending Physicial within 24 hours after death. To the Funeral Director: After this cer completely filled in by the funeral direct	Certification:	1 Natural 5 Pending Month, Day, Year Pd 8/11/)	am 1	yes 2 No	unk	how injury occurred	
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		4 Homicide determined (Specify) fo	und: resid	ence		Rd. Ess	sex, MD	or Rural Route Number, City Nurenschmidt
To the Hos within 24 h To the Fun completely	edica	(Check only one) 2 Medical Examiner: On the basis of examinand manner stated.	nowledge, death occurr nation and/or investigati	red at the time, d	late and place, and n, death occurred	d due to the caus at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
		29b. Signature and title of certifier Club Le UV	- W C2 :	29c. Licens			29d. Date signed August 12, 20	(Month, Day, Year) 010
		30. Name and address of person who completed cause of deal Laron Locke MD. Assistant Medical Exam	iner 111 Penn	Street, Baltii	more, MD 212	201		
Sta	ite	31. Date filed (Month, Day, Year) 22. Registrar's	Signature					

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

0-06015		Please Type or Print in Black Indelib	le Ink. Ensure All Co	pies Are Le	aible.
Robert Settles	, Sr.	State of Maryland / Departme	nt of Health and Mental	Hygiene	2010 2582
- Division		Registrar	e of Death		leg. No.
Physic Medical Exan			as Sr	2. Date of Dea Month August 11	
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of De	1, 2010 0418 hrs	
		1611 Cypress Street	Baltimore	N/A	
Funera		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd			rth(MM/DD/YYYY) 9. Birthplace (State or
Directo	r	214 66 4664 1XM 2 F 57	Yrs. Months Days Hours	Min. 04/27	7/1953 Foreign CountrMaryland
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location		
. ≰		Monyland N/A Pale	imore		10d. Inside City Limits 1 XYes 2 No
Aaryland 28a-f show 1 at once,	Director	10e. Street and Number	10f. Zip Code		Og. Citizen of What Country?
th the Maryland 23a or 28a-f she notified at once		1611 Cypress Street	21226	l i	U.S.A.
n with ms 23 be no	era	11. Marital Status 12. Was Decedent Ever in U.S. 1	3. Was Decedent of Hispanic Origin?	Specify Yes or No	
r death or ite	Funeral	Never Married 2 Married 1 X Yes 2 No	If Yes, specify Cuban, Mexican, Pue	erto Rican, etc.)	White, etc.
rs afte rrai",	à	3 Widowed 4 X Divorced If Yes, Give Year or Dates:	1 Yes 2 X No specify:		_{Specify:} White
136 hin 72 hours aft e. than "natural' edical Examine	ompleted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	edent's Usual Occupation (Give kinding most of working life. DO NOT use	of work done retired)	16b. Kind of Business/Industry
036 thin 7 ne. than	롈	9th	Janitor		Restaurant
5-0 Hygie other	10	17. Father's Name (First, Middle, Last)		me (First, Middle, N	
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygene. tealth and Mental Hygene. team 27 is anarked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once.	Be	John F. Settles Si		etty	(not available)
MD 2 d 2 shoul lth and N n 27 is m	ြင		ailing Address (Street and Number of		
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after and rot of Health and Mental Hygene. ant: If them 27 is marked other than "natural", or other traumatic event, the Medical Essaminer.		20a. Method of Disposition 20b. Place of D	1 Cypress Street	Date	more, Maryland 21226 20c. Location - City or Town, State
Baltimore, bermit. Pages I as Department of He Important: If ite		1 ABurial 2 Cremation 3 Removal from State crematory	or other place)		
Baltimo permit. Page Department of Important:				onco Funo	Baltimore, Maryland ral Service, P.A.
iii II Deg	1	Umna M. Framiroushi	4001 Ritchie Hig	hway Balt	imore, Maryland 21225
Physician /Medical		23a. Part I. Enter the dise of or complications that caused the death. Do not en failure. List only the dise on each line.	ter the mode of dying, such as cardiac	or respiratory arre	st, shock, or heart Approximate Interval Between Onset and
Examiner	11	Immediate Cause (Final disease a. Narcotic (methado	ne) intoxication		Death
		bue to (or as a consequence or).			
	Je.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
xecuted 1 and - transit		dd.			
e exection a cian a irial - 1	dical	XUNPENDED AMENDED 23a,27,28a-f,per	ME 9908 10/4/10	ጥጥ	
68760, certificate be nding physici	ian/Medi	23b. Was decedent pregnant in the	TIL 8500 10/4/10	11	23d. Date of delivery
cords, P.O. Box 68760, law requires that the death certificate be exhat seen signed by the attending physician be as should be detached for use as the burial.	cian	past 12 months? 1 Live birth 2 4 Pregnant at time of death	Fetal death 3 Ectopic preg	nancy	Month Day Year
Boy e death the att	Physici	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)		
P.O. s that the	by P	Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause given in Part I.	23e. Did tob	acco use contribute to the cause of death?
S, P				1 Yes	2 No 3 Probably 4 Unknown
ord aw req	Bet			24a. Was ar autopsy	
Rec The l	Completed			perform 1 ✓ Yes 2	ned? death?
Vital Recysician: The Inis certificate	Be	25. Was case referred to medical examiner? Hospital: 1 Inspirate 2 FR/Outst	26 Place of Death (Check		
Division of Vital Records, ral or attending Physician. The law requirers after death all Director: After this certificate has been sited in by the funeral director, page 2 should be	P	1 Yes 2 No Inspire 1 Inpatient 2 ER/Outpat 27. Manner of Death 28a. Date of Injury 28b. Time			esidence 6 Other: Scene
on of anding Ph	Certification:	1 Natural (Month, Day, Year)		28d. Describe ho	w injury occurred
Division pital or Attencours after death leral Director: filled in by the	<u>g</u>	2 Accident Investigation 28e Place of Injury - At home farms	<u> </u>		eet and Number or Rural Poute Number City
Diving a final or ours affi	E	4 Homicide determined (Specify) residen		Baltimo	eet and Number or Rural Route Number, City te) 1611 Cypress St Dre, MD
e Hosp 24 ho e Func etely f		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death or	curred at the time, date and place, an	d due to the cause(s) and manner as stated.
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atten completely filled in by the funeral director, page 2 should be detached for u.	Medical	one) 2 Medical Examiner: On the basis of examination and/or invest and manner stated.	gation, in my opinion, death occurred	at the time, date an	d place, and due to the cause(s)
	2	29b. Signature and title of certifier	29c. License number	2	29d. Date signed (Month, Day, Year)
4		Theodow M. King Jay m.	O.C.M.E. 00	ME	August 11, 2010
Ø I		30. Name and address of person who completed Juse of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner	111 Penn Street, Baltimor	- MD 21201	
Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	TTT GIRL Street, Daitimol	C, IVID 21201	
Regist		AliG 1 8 2010 /			

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 2010 25828 State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Certifica	te of L	Death	_		Reg. No	O	
Physici Medical Exam							2. Date of Month August	Dav	Year	3. Time of Death 1854 hrs
À		4a. Facility Name (if not institution, give street and number) E/B I - 68 E/ O Street Road			City, Town, o Cumberlar		of Death		tc. County o Allegany	
Funeral Director		220-94-1020 1XM 2 F	yrs. last birtho	day) Yrs.	If Under 1 Ye Months Da	-				9. Birthplace (State or Foreign Country Maryland
my		Usual Residence of Decedent 10a. State 10b. County 10c.	City, Town or	r Location						10d. Inside City Limits
Aaryland 28a-f show any Lat once,	Ē	Maryland Baltimore	1	Dunda	a1k					1 Yes 2 X No
with the Maryland ns 23a or 28a-f sho be notified at once,	Director	10e. Street and Number 1941 Stanhome Road		1	Of. Zip Code	1222			itizen of Wha	
3, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland lealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she trammatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2	10	If Yes,	specify Cuba	an, Mexican	gin? (Specify Yes or , Puerto Rican, etc.)	No-	White,	
ırs afte ural", miner	by	3 Widowed 4 Divorced If Yes, Give Year 87 - 15. Decedent's Education (Specify only highest grade completer	89 d) 16a. De		es 2 X N		kind of work done	16b.	Specify: Kind of Bus	White siness/Industry
72 hou n "nat al Exa	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	du		of working lif					,
0036 within iene. er tha	ldu	2	Mai	rine	Mecha				Mar	ine
15-003 filed withi I Hygiene. d other th							's Name (First, Midd		•	
21215-0036 vald be filed within 7 Mental Hygiene. marked other than cevent, the Medisa	o Be	Larry W. Trimble 19a. Informant's Name/Relationship (Type, Print)	19b.	Mailing A	ddress (Stre	_	garet L. F			, State, Zip Code)
nore, MD 3 ages I and 2 sho nt of Health and it: If item 27 is other traumatic		Diane Friel, Sister					altimore,			
re, M 1 and 2 F Health f item 2			Ob. Place of cremator	Disposition y or other		emetery,	Date	20c	Location - 0	City or Town, State
Baltimore, permit. Pages I an Department of Hee Important: If ite		4 Donation 5 Other Specify:	etro Cı	remat	ory, Ir					e, Maryland
Baltimo permit. Page Department of Important:		21. Signature of Funeral Service Licensee Amanda Heas	ston							Maryland, Inc
		23a. Part I. Enter the disease, or complications that caused the de	eath. Do not							rt Approximate Interval
Physician		failure. List only one cause on each line.	, DO 1101			,	araido or roopiratory	u., oo,	iout, or mou	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence)	ce of):							
	L	Sequentially list conditions, b.								
	Examiner	if any, leading to immediate Due to (or as a consequent cause. Enter Underlying Cause c.	ce of):							
d sit	xan	events resulting in death) Last Due to (or as a consequence	ce of):							
xecute n and - tran		d. UNPENDED AMENDED								
760, icate be executed physician and the burial - transit	Medical		rognoncy					1 22	3d. Date of d	Ioliyon
876 rtificat ing ph as the	~	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of past 12 months?	2 [Fetal	death 3	Ectopic	pregnancy	23	Month	Day Year
Box 68 e death certifi the attending	Physician	4 Pregnant at time of the Yes 2 No 9 Unknown 9 Unknown	of death 5	Other	(Specify)			- 1		
that the de detached f	Phy	Part II. Other significant conditions contributing to death but n	ot resulting i	n the unde	erlying cause	given in Pa	rt I. 23e. Di	d tobacco	use contrib	ute to the cause of death?
r, P.O. ires that the signed by	d by						1 🔲	res 2	∕ No 3 [Probably 4 Unknown
ords, w requir s been s should	Completed						24a. W	as an topsy		ere autopsy findings available for to completion of cause of
eco he law tte has	m							rformed?	de	ath? Yes 2 No
ital Reco ician: The law certificate has	ابه	25. Was case referred to medical			26.Plac		Check only one)	• = [],		y 165 2 1.15
Vits hysicia this ce	8	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2	ER/Outp	patient 3	DOA	Other ₄	Nursing Home 5	Reside	ence 6 🗸	Other: Scene
Division of Vital Records, tal or Attending Physician: The law requir rs after death. al Director: After this certificate has been seled in by the funeral director, page 2 should!	tion: T	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) Aug 12, 2010	28b. Tin 1839 h	ne of Injur 168		ury at Work? Yes 2 ✔	Driver aut			d
Divisi pital or Att ours after de teral Direct	ertification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Interstal	At home, farm te/Express		actory, office	building, etc	or Town	, State)		or Rural Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deached for use as the burial - trans	Medical C	29a. Certifier 1 Certifying Physician: To the best of my know one) 2 Medical Examiner: On the basis of examination and manner stated.								
E 2 E 3	Me	29b. Signature and title of certifier	1		29c. Licen:	se number		29d.	Date signed	(Month, Day, Year)
		Calluna	1		O.C.	M.E.		Aug	gust 13, 2	2010
104//	Ì	30. Name and address of person who completed cause of death (I)	Street D	time are to	4D 24204			
10.		Zabiullah Ali, M.D. Assistant Medical Examir 31. Date filed (Month Day Year) 32 Registrar's Sign		Penn S	Street, Bal	ımore, M	21201			
St Regist	ate trar	AIII T Q 2010 1 20	A	Bock						
DHMH 17 Rev 1/2	001		ORIG	SINAL						DUME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#2,23a,pt1,perPHYS,g906,8/18/2010,ws

State of Maryland / Department of Health and Mental Hygiene 25829 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2010 1636P Herman D. Wistland, Jr. August 1 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake
5. Social Security Number | 6. Se BelAir Harford If Under 1 Year 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Months Min Yrs 73 213-34-7471 November 30,1936 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☐ Yes 2 ☐ No Md. Balto. Perry Hall 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4600 Silver Spring Road 21128 IISA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ₩ Never Married 2 Married White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Planter Planter Horticulture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Herman D. Wistland .Sr Thelma A. Landefeld 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jeannette D. Currey Sister 4600 Silver Spring Rd. Perry Hall, Md. 21128 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition tX Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith 8-4-2010 Balto. Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Road Nottingham, M d, 21236 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line Lung Mass Immediate Cause (Final disease or condition resulting in death) Due to (or as a co uence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 🗆 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? Concer 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an autopsy performed Yes 2 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27 Manner of Death 28c. Injury at Work? Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b, Signature and title of certifier

/Medical Examiner Wistland, Herman Daniel Tr. 17 P.O.1 of Vital Records, To the Hospital or Attending within 24 hours after death. To the Funeral Director: After

> State Registrar

31. Date filed (Month, Day, Year)

AUG 0 3 2010

Physician

/Medical

Examiner

Director

Be Completed by Funeral

2

Physician/Medical Examiner

Completed by

Be

Medical Certification: To

as the

for use

ned by the a

signed by

page

completely filled in by the funeral

Funeral

Director

Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

and Mental

permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any Injury or other traum once.

Physician

SIIII 1036 Pm Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

500 Upper Cherapake

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b per fh 9906 8-18-10 Wental Hygiene State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 12 2010 Edward Anthony Wilson Sr. /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c County of Death Examiner 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year 3 / 7 / 1 9 3 2 7. Age (In yrs. last birthday) Social Security Number **Funeral** Hours X□M 2□F Months Days Min. 212-34-2396 NY Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a Madical Evantice must be notified a once. Director Baltimore Middle River 1 ☐ Yes 2 Tho MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 65B Oak Grove Drive USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: UNK Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 □Yes 2 X No þ Specify: 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Johns Hopkins Univ. Elementary/Secondary (0-12) College (1-4or 5+) Machinist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Andrew Wilson Mary Gonia ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12415 Eastern Ave, MIddle River, MD 21220 Cheryl Thompson (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 8/13/08 1 ☐ Buria! 2 X Cremation 3 ☐ Removal from State Orlando, FL Orlando Crematory 4 ☐ Donation 5 ☐ Qther (Specify) 21. Signature d Funeral ervice Licensee 22. Name and Address of Facility 8018 Sunport Drive, Suite 205 Orlando, FL 32809 MedCure 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) O. **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician: The law requires that the death certificate be executed g physician and s the burial-trans Due to (or as a consequence of): Physician/Medical as attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Dav Year 5 Other (specify) signed by the a P.O. 9 Hlaknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? has 2 No 1 ☐ Yes 2 ☐ Mo 1 ☐ Yes : After this certific funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 6 ☐ Other (Specify) To the Hospital or Attending Pleath.
within 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🕯 🚾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title 29c. License number 08-12-10 RESOODO 30. Name and address ∮f person who completed cause of death (Item 23a) (Type, Print) Romano, 9000 Franklin Square Drive, Baltimore MD. 21237 Registrar

Edward

/ DHMH 17 Rev 7/2009

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) •

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 25833 amend item 2 per doc. 19a per fin g906 8-18-10 vt.

			1 = For State Registrar	State of Maryla		artment of F		d Mental Hy	/giene		200			
	Physicia		1. Decedent's Name (First, Middle, Last)	Naomi	Q. Wo	rthingt	on	2. Date of D Month 8	Day)10 Year 945	3. Time (of Death		
	/Medio Examin		4a. Fecility Name (If not institution, give s	treet and number)		4b. City, Town, o	r Location of D	eath	4c. County			<u> </u>		
H	LXamiii	C.	Manor Care Fall	s Road		Balti	more		na					
	Funeral Director	100	5. Social Security Number 6. Sex 241-30-3549	3.7	rs. last birthday) 88 Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of B Win. (Month, D	irth 1921	Cou	place (State intry) N 。 C	or Foreign		
	p		Usuel Residence of Decedent		a: = 1						10d. Inside (Cibi Limite		
	show	-	10a. State 10b. County		City, Town or Lo							s 2 □ No		
	8e-f.	cto	MD na	a B	Baltimo				40- 05	4/b-14 C-1				
	vith th	Director	10e. Street and Number	7.1		10f. Zip Code	2		10g. Citizen of \		iriti y r			
	s 23s	ra	1809 N. Wolfe S	Street 12. Was Decedent Ever in	0116 13	2121		2 (Specify Ves or N			ican Indian,			
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland of Mental Hygiens. marked other than "natural", or Items 23a or 28e-f show maric event, it a Medical Examinar must be rediffed at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		f Yes, specify Cubin	Specify:	? (Specify Yes or N luerto Rican, etc.)	Bla Specify	ck, White				
Ž	72 ho	ted	15. Decedent's Educ (Specify only highest grade	ation	16a. Dece	dent's Usual Occup	ation	working	16b. Kind of B	usiness/l	ndustry			
2	thin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	d)		Marrio	att	Food	Ser.		
7	filed withi Hygiene. other then	Co	10th grade			Cook								
2	be fill stal Hy ad oth	Be	17. Father's Name (First, Middle, Last)					Name (First, Midd)	e, Maiden Suman	10)				
<u>\S</u>	should be ind Mental is marked o	7	Arch Quinterly		405 44 50	A	Rosa	- O 1 O 1 N	has City as Taum	State 7	in Cada)			
ā	E . 5		19a. Informant's Name/Relationship (Type Rodock Worthing)	e, Print) Con Son Son				r Rural Route Num Road Sp				22153		
a)	1 and 2 Health tem 27 l		20a. Method of Disposition		b. Place of Dispo	sition (Name of		Date	20c. Location					
Baltimore,	Pages ment of I tant: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Ro 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	King M	matory or other pla emorial	Pk 8-	-13 - 2010 March Ea	Randa	llst		MD		
Ball	permit. Pag Department Important: I any Injury o once.		21. Signature of Funeral Service License	K. Jmes	22	Name and Addre	Nort	th Avenu	ie Ba	lto,	MD :	21202		
- 53			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
Í	Physician		Immediate Cause (Final disease or condition	\mathcal{D}	EME	VITA					Onset and	Death		
	/Medical		resulting in death)	Due to (or as a con	sequence of):	C + 0		. 1						
Ш	Examiner		Sequentially list conditions		AIED	MILS) DOW	HOPATH	7					
#	p #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con-	sequence of):									
	be executed sician and burial-transit	cam	that initiated events resulting in death) Last	Due to (or as a con	coguence of):									
50,	cian sourial	E E		Due to (or as a con-	sequence or).									
8760	physin physin s the b	dical	d											
9 ×	death certificate be executed e attending physician and nd for use as the burial-transit	Physician/Me	IF FEMALE:	3c. If yes, outcome of pre	egnancy				23d Da	ate of deli	very			
Вох	atten for u	lan	in the past 12 months?	1 Live birth 2 ☐ F	Fetel death 3	Ectopic pregnance Other (specify)	у			onth	Day	Year		
o	that the de ed by the a detached t	yslo	1 Yes 2 No 9 Unknown	9□ Unknown										
ص َ	The law requires that the site has been signed by the bage 2 should be detache.		Part II. Other significant conditions con	tributing to death but not	resulting in the u	nderlying cause giv	ven in Part I.	23e. Dio	I tobacco use con	tribute to	the cause of	f death?		
ds.	uires sign	d by						1]Yes 2□No	3 □ Pro	obably 4	Unknown		
Records,	w require been si should b	Completed						24a. Wa	is an 24b.	Were au	topsy finding	s available		
Re	he lav e has age 2	mc						per	formed?	prior to c death? 1 \(\text{Yes}	_	cause of		
Vitaľ		Be C	25. Was case referred to medical				26. Place of	Death (Check only		103	200 110			
	yelci s cer direct	0	examiner?	lospital:	2 ER/Outpatie	nt 3 DOA Ott	100	ng Home 5 ☐ Re		her (Spec	cify)			
0	Attending Physicien: It death. sctor: After this certification by the funeral director.	T:U	27. Manner of Death	28a. Date of Injury (Month, Day Yea	28b. Time o	f 28c. Inju	ry at	28d. Describ	how injury occur	rred				
0	utending I death. ctor: After y the funer	atlo	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(**************************************	, ,,,,,,		Yes 2 □No							
Division of	or Attencater death Director: in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp		reet, factory, office			(Street and Num. own, State)	ber or Ru	ral Route Nu	ımber,		
_	Hospitel 4 hours Funerel ely filled	edical C	(Check only, 2 Medical Examir	sician: To the best of my ner: On the basis of exam								e(s)		
	To the He within 24 To the Fu	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens	se number		29d. Date signe	ad (Monti	n, Day, Year)		
	T CO	_	M				7723	}	28/	10	1			
			HMM NIV		(14		, , , ,		001	1	10			
	1) \		30. Name and address of person who co	propleted cause of death ((Item 23a) (Type,	2 Wall	Man	n No	do 11	mo	of in	112123		
	Sta	to.	31. Date filed (Month, Day, Year)	32. Registrar's S	ignature	1 04-00	, , , , , , ,	1 / / / /		(1	.,, -, -,		
	Sta Registi		AUC 10 00	· A	. 4	and I								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 21 per fh g906 8-18-10 vt State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 11^{Day} Uldine U. Zborowski 2010 ear 7:00 August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Baltimore Examiner Catonsville Frederick Villa Nursing & Rehab. Date of Div. (Month, Day, 9. Birthplace (State or Foreign . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Months Days Hours 1 M 2 X F Maryland 220-24-9218 81 1928 Director Sept Usual Residence of Decedent or 28a-f shov 10b. County 10d, Inside City Limits 10a, State 10c. City, Town or Location filed within 72 hours after death with the Maryland r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Catonsville Baltimore MD 1 🗌 Yes 2 🏻 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21228 711 Academy Road 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. \$ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ₩ No Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Menones. Elementary/Seconday (0-12) 12 College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Zella Crockett Clifford Bowen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Howard Roland, Attorney 6024 Moorehead Rd., Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗷 Burial 2 🗌 Cremation 3 🗌 Removal from State Holy Rosary Cemetery 8/16/2010 Dundalk, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke . Signature of Funeral Service Licenses Mary K. Hackman M01050 per dvr 1630 Edmondson Ave., Catonsville MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
3 weeks Immediate Cause (Final Congestive Heart Failure Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause (Disease or linjury Due to for as a consequence of: • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 1 ☐ Yes 2 ☐ 9 ☐ Unknown been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 M Probably 4 ☐ Unknown completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed?

1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes ျ 2 🔽 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1X Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the lewithin 2 To the F only one 29c. License number 29d. Date signed (Month, Day, Year) 81gnature and title of certifie D23365 2010 est 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patrick W. White, MD 405 Frederick Road, #202, Baltimore MD 21228 31. Date filed (Month, Day, Year) State AUG 182010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryland		irtment of tificate of			giene Reg. No. 2010	25835
			Decedent's Name (First, Middle, Last)			imouto or	Dout	2. Date of Dea		3. Time of Death
	Physicia Medic				Ackers			Month	8 10	2235™
)	Examin	er	4a. Facility Name (if not institution, give stree WMHS-RMC	t and number)			or Location of Denberland	eath	4c. County of Dea	
- Janes	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year Months Day	r If Under 24 F		b 0.03	Abeles - (Ot-t- or Faraign
· ·	Director		212-38-5096 1 L _x M	^{2 □} F 70	Yrs.	Months Day	S Hours IVI	Oct 1	4, 1939 Co	ountry) MD
	and show	tor	10a. State 10b. County		, Town or Loc					10d. Inside City Limits
	Maryl 28a-f otifie	Director	MD Allegan	iy	Cui	mberlan				1 ☐ Yes 2 ☐ No
	ith the 23a or st be r		10e. Street and Number 13006 Lewis Heigh	nte Dr. S.W		10f. Zip Code	2150	2	10g. Citizen of What C	
	within 72 hours after death with the Maryland glene. et than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at the Medical Examiner must be notified at	Funeral	11. Marital Status 12.	Was Decedent Ever in U.S		/as Decedent of		(Specify Yes or No-	14. Race - Am	erican Indian,
36	after d Il", or i xamin	by	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 1960	1	Yes 2		erto riicari, etc.,	Black, Whi Specify:	white
8	hours natura Iical E	Completed	15. Decedent's Educat	tion	16a. Deced	ent's Usual Occ			16b. Kind of Business	
21	hin 72 ne. than "ı e Mec	omp	(Specify only highest grade of Elementary/Seconday (0-12)	ompleted) College (1-4 or 5+)	life. DC	NOT use retire	•	vorking	Daata	
22	Hygier Hygier other ent, th	Be C	17. Father's Name (First, Middle, Last)		Own	er/opera		Name (First, Middle,	Restaura Maiden Surname)	ını
/lan	d be filed Mental Hyg arked oth atic event,	욘	Raymond F. Ack	erson			Ce	celia (Mo	nahan) Ack	erson
Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If health and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type, F Christopher Ackers	_	19b. Mailin 13	g Address (Stre 8006 Le\	et and Number or wis Heigh	Rural Route Number	r, City or Town, State, Z mberland	MD 21502
Baltimore,	le 1 and t of Heal If item 3 or other		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Rem	20b. Pl	ace of Dispos emetery, crem	sition (Name of latory or other p	lace)	Date 8/12/201	20c. Location - City o	
Ħ H	permit. Page 1 a Department of H Important: If ite any injury or oth		4 ☐ Denation 5 ☐ Other (Specify) 21. Signature / Funeral Service Licensee	Su				8/12/201	O Cumber	rland MD
Ba	permit. Departr Importa any inji		21. Shatole Melal College		22.			al Home, PA enue: Cumbei	rland, MD 21502	2
			23a. Part 1 Enter the disease, or complicat shock, or heart failure. List only one ca	ions that caused the death use on each line.	. Do not ente	r the mode of d	ying, such as card	iac or respiratory arr	rest,	Approximate Interval Between
-	nysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a cor sequ	ence of:	F-11				Onset and Death 4 a 445
	Examiner		Conventible list conditions	End	Stag	e Rev	ial Fo	ailure		
	sit sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or liniury	Due to (or as a consequ						
d	executed an and rial-transi	Exa	that initiated events resulting in death) Last	Due to (or as a consequ	ence of):					
09	rate be executed physician and the burial-transit	dical	d							
189	ertifica ding p se as t		IF FEMALE: 23b. Was decedent pregnant 23c.	If yes, outcome of pregnar	ncy				23d. Date of de	alivery
. Box	death c e atter ed for u	Completed by Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 □ Live Birth 2 □ Fetal 4 □ Pregnant at time of d 9 □ Unknown		Ectopic pregna Other (specify)			Month	Day Year
P.O.	at the d d by th etache	Phy	9 ☐ Unknown Part II. Other significant conditions contrib		ulting in the ur	nderlying cause	given in Part I.	23e Did to	obacco use contribute t	o the cause of death?
S,	ires th signe Id be d	d by	Crohn dis	ease						Probably 4 🕅 Unknown
örd	w requ s beer 2 shou	plete						24a. Was		utopsy findings available completion of cause of
Ř	The la	Com						perfo	rmed? death?	
ta	sician: certific rector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hosp	ital:			Place of Death (C			
o t	g Physer this neral di	te: To	27. Manner of Death	1 Na Inpatient 2 128a. Date of injury (Month, Day, Year)	ER/Outpatient 28b. Time of injury	28c. In	4 LI Nursin		dence 6 Other (Spenow injury occurred	cify)
<u>0</u>	tendin leath. tor: Aff the fur	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be			M 1	Yes 2 No			
Division of Vital Records,	tal or Atrs after of al Directed in by		4 Homicide determined	8e. Place of Injury - At hor building, etc. (Specify)	ne, farm, stre	et, factory, offic	e	28f. Location (S City or Tow	Street and Number or Ri n, State)	ural Route Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death certificate be within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the but	Medical	29a. Certifier 1 Z Certifying Physiciar (Check 2 Medical Examiner: only one) 3 Certifying Nurse Properties	On the basis of examination	and/or investi	gation, in my op	inion, death occurr	ed at the time, date a	and place, and due to the	cause(s) and manner stated.
-	To th within To th comp	_	20h Signature and title of certifier			20c Lice	nee number		20d Data signed /Mon	
	1		30. Name and address of person who compiled the first of the compiled (Month, Day, Year)	eted cause of death (Item	23a) (Type, Pi	rint) A	OLAG	DALCAA	(Mulana	mod Nacem)
	7		625 Kem Ave 31. Date filed (Month, Day, Year)	Sul 204	Cen	ulien/c	met My	121502	- Chimnami	THE TURE EM
	Stat Registra	_	AUG 182010	32. Registrar's dignate	TELLO	7				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / Dep	partment of Health and Nertificate of Death		ene 3. N2 0 1 0	25836
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Fehmida Akhtar		2. Date of Death Month July 2	Day Year 2010	3. Time of Death 10:00 pM
	Examir		4a. Facility Name (if not institution, give street and number) 13104 Eddington Drive	4b. City, Town, or Location of Death Upper Marlbore		4c. County of Death	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 229-23-3942 1 M 2 XF 70 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, You Feb. 2.2	ear) Cour	place (State o <i>r Foreig</i> n htry) akistan
	aryland a-f show ified at	Director	10a. State 10b. County 10c. City, Town or Lo	ocation Marlboro			10d. Inside City Limits 1 ☐ Yes 2X☐ No
	with the M 23a or 28 ust be not	Funeral Dir	10e. Street and Number 13104 Eddington Drive	10f. Zip Code 20774	10	g. Citizen of What Cou USA	ntry?
9800	should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	þ	1 Never Married 2 Married 1 Yes 2 No	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ▼No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: AS	
Baltimore, Maryland 21215-0036	within 72 hou giene. er than "natu the Medica	Completed	(Specify only highest grade completed) (Give Elementary/Seconday (0-12) College (1-4 or 5+)	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) emaker	ing 16	Own Home	dustry
yland	ould be filed of Mental Hyg marked oth maric event,	To Be	17. Father's Name (First, Middle, Last) Abdul Huq	18. Mother's Nam Iqbal I	e (First, Middle, Mai Begam	iden Surname)	
, Mar	1 and 2 should be of Health and Men item 27 is marke other traumatic		Zaheer Akhtar-son 132	ing Address (Street and Number or Run 109 Keverton Dr.	al Route Number, Ci . Upper	ity or Town, State, Zip (Marlboro	, MD 20774
imore				osition (Name of ematory or other place) ad National 07/2		oc. Location - City or To Laurel	
Ball	permit. Page Department of Important: If any injury or once.	a d		A Name and Address of Facility Thibadeau Mortuary Park Ave., Gaith)
-	nysician/		23a. Part 1 Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	ter the mode of dying, such as cardiac o	or respiratory arrest,		Approximate Interval Between Onset and Death
	Medical Examiner	er	resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.	Follure			14
Ъ	ecuted and Il-transit	Examiner	In any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last				
09/	cate be ey physiciar s the buris	dical	d				
. Box 687	To the bropping of Artending Priysician: The law requires that the clearlincate be executed within 24 hours after death. To the Funeral Directors After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown	Ectopic pregnancy Other (specify)		23d. Date of deliving Month	ery Day Year
s, P.O.	ilres that the signed by Id be deta	d by Pl	Part II. Other significant conditions contributing to death but not resulting in the Congestive Acan't Failure			cco use contribute to the	ne cause of death?
Vital Records,	ne law requ te has beer age 2 shou	Completed	Diabetes Mellitus		24a. Was an autopsy performe	prior to co death?	psy findings available mpletion of cause of
Vital	ysician: I s certifica director, p		25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	26. Place of Death (Check	only one)	e 6 Other (Specify	
on or	ending Phi ath. r: After thi ne funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day, Year) 28b. Time of injury		28d. Describe how		
UIVISION	ital or Atternor al Directo		3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural state)	Route Number,
	me nospi hin 24 hou the Funer npleted fill	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or invesonly one) 3 Certifying Nurse Practioner: To the best of my knowledge,	stigation, in my opinion, death occurred at death occurred at the time, date and place	the time, date and pee, and due to the car	blace, and due to the car use(s) and manner as st	use(s) and manner stated. ated.
	5 P IS		29b. Signature and title of certifier way word my	29c. License number		Date signed (Month, 7	pay, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type, I George B Cavanagh, M.D. 4201 Mitchel	lville Rd: Bowie	MD 20716	,	
	Stat Registra	G	31. Date filed (Month, Day, Year) AUG 02 2010 33. Registrar's Signature	wed			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25837 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2818A Maian E. Blanchett Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Doctors Community Hospital Prince George Lanham Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 🕱 F Hours Month, Day, Year) Director 102-09-0764 93 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location Director 10d. Inside City Limits MD Prince George Lanham 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6414 Brightlea Dr. 20706 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, rmed Forces? Black, White, etc. by 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 X Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Contracts/ Procurements US Navv Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Albert Lamont Funkhouser Lilly Dale Carson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roy Strang/ Son 6414 Brightlea Dr., Lanham MD 20706 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 \square Burial 2 \square Cremation 3 $ilde{X}$ Removal from State Oak Park Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 8/11/2010 New Castle, PA 21. Signature of Juneral Service Licensee 22. Name and Address of Facility found And Sons Funeral Chapel Joseph w Misko 850 Sperryville Pike Culpeper VA. ZZ701 M01080 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MYOCARDIAL INFARCTION disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events sequentially indeeds). Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death 9 Unknown 9 🗀 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖭 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate har funeral director, page 1 ☐ Yes 2 ☐ No Yes 2 W 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No 욘 1 Inpatient 2 ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27 Manner o≱Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: A
completed filled in by the f Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) MDD54675 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8118 GOOD LUCK RD. LANHAM, MD. 20704 Arora, mi).

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		State of Maryland / Department of the Properties		ygiene 2010 2	2583
Physicia ical Examir	n/	1. Decedent's Name (First, Middle, Last)		2. Date of Death 3. Time	e of Death
)		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death	
Funeral		Harford Memorial Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Havre de Grace If Under 1 Year If Under 24Hrs	Harford 8. Date of Birth/(MM/DD/YYYY) 9. Birthplace Foreign Af	(State or
Director		212-82-2287 1XM 2F 49 Yrs	Months Days Hours Mir	12/15/ 2010 Foreign Country) M	aryland
Maryland 28a-f show any d at once.		10a. State 10b. County 10c. City, Town or Local Maryland Harford Havre de			rside City Limits Yes 2 No
ith the Maryland 23a or 28a-f sho notified at once	as I	10e. Street and Number 106 Deaver Street	10f. Zip Code 2 1 0 7 8	10g. Citizen of What Country? United States of	America
7.15-UU30 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once		1 Never Married 2 Married Armed Forces? If Yes 2 No	As Decedent of Hispanic Origin? (See, specify Cuban, Mexican, Puerto		an, Black,
filed within 72 hours a lifted within 72 hours a liftygiene. Ed other than "natura t, the Medical Exami	Completed b	Flementary/Secondary (0-12) College (1-4 or 5+) during m	nt's Usual Occupation (Give kind of nost of working life. DO NOT use ret aller		
Mental Hygiene. Mental Hygiene. marked other than "na	Be Con	17. Father's Name (First, Middle, Last) Walter G. Boyd		e (First, Middle, Maiden Surname) E. Collins	-
d 2 should I d 2 should I lth and Mer n 27 is man		Jessica Boyd (daughter) 1350.	South Cypress Ro	Rural Route Number, City or Town, State, Zip Co ad, Pompano Beach, Flo	de) 33060 Orida
IMOFe, Pages I an nent of Hea ant: If iter or other tr		1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify: RA Ferris	& Co., Inc. 08-	Date 20c. Location - City or Town, S 02-2010 WestChester, Pe	ennsylva
permit. Departr Departr Import	Δ	Yara C. Sellman 12	3 S Washington S	llman Funeral Home, P. t., Havre de Grace, Ma	
hysician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	the mode of dying, such as cardiac		oximate Interva veen Onset and Death
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause			
uted od ransit	Exam	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.			
cate be execut physician and he burial - tra	Medical	UNPENDED X AMENDED #8perFH, G907, 9	/8/2010,WS		
certifi nding ise as t		23b. Was decedent pregnant in the past 12 months?	etal death 3 Ectopic pregn	23d. Date of delivery ancy Month Day	Year
ires that the de signed by the	by Phy	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause 1 Yes 2 No 3 Probably 4	
law requir has been s 2 should b	ompleted			24a. Was an autopsy fir prior to completing death? 1 Yes 2 No 1 Yes	ndings available
certificate ector, page	C) L	25. Was case referred to medical examiner?	26.Place of Death (Check		
g Physician: fter this certif neral director,	ၟႍႃ	1 ✓ Yes 2 No Inpatient 2 ✓ ER/Outpatien		ng Home 5 Residence 6 Other: 28d. Describe how injury occurred	
tending Ph eath. tor: After the funeral		1 Natural 5 Pending FOUND: FOUND:	1 Yes 2 ✓ No	Subject hanged self	
spital or Atte	Certification	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Shed	et, factory, office building, etc.	28f. Location (Street and Number or Rural Roul or Town, State) 106 Deaver Street, Havre de Grace, MD	te Number, City
To the Hospital or Attence within 24 hours after death To the Functal Director: completely filled in by the	Medical Co	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigations.	rred at the time, date and place, and ation, in my opinion, death occurred	d due to the cause(s) and manner as stated. at the time, date and place, and due to the cause	e(s)
T ₀ Y ₀	¥.	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day	/, Year)
		Follow Poll	O.C.M.E.	July 28, 2010	
5	ļ	30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner	111 Penn Street, Baltimo	re, MD 21201	
	ite	31. Date filed (Month, Day Year) 32. Registra's Signature			

DHMH 17 Rev 1/2001 OCME 2006

Debbie	0	Brown Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.	
UNK UNK		State of Maryland / Department of Health and Mental Hygiene	25839
Physicia		Reg. No.	Time of Death
Medical Exami		Debra Ann Brown July 18, 2010 Year 1	1356 hrs
)		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Baltimore	e
Funeral Director		5. Social Security Number 222-60-2533 6. Sex 7. Age (In yrs. last birthday) 47 Yrs. Months Days Hours Min. 5-3-1963 Foreign Country	DE
nd show any	٥r	MD Baltimore Baltimore	1. Inside City Limits XYes 2 No
the Maryli 3a or 28a-f	Director	10e. Street and Number 3401 E. Baltimore St. 10f. Zip Code 21224 USA	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I filem 27 is marked other than "natural", or items 23a or 28a-f show injury or other tranmatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced of Dates: 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 1 Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American In White, etc. 15. Was Decedent Ever in U.S. Armed Forces? 1 Yes, specify Cuban, Mexican, Puerto Rican, etc.) 16. Race - American In White, etc. 17. Was Decedent Ever in U.S. 18. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 19. Was Decedent Ever in U.S. Armed Forces? 10. Yes 2 No 11. Yes 2 No specify: 11. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 10. Was Decedent Ever in U.S. 11. Race - American In White, etc.	indian, Black,
)36 thin 72 hours ite. than "naturi edical Exami	ompleted b	AS BOOK OF THE STATE OF THE STA	stry
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Bec	E. Kirk Brown III Roberta Hye	
MD 2' nd 2 should alth and M m 27 is ma	_	3 , 1 3,	9934
Baltimore, permit. Pages 1 an Department of Hel Important: If ite		20a. Method of Disposition 1	, MD
Balt permit. Departu Import injury		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Pippin Funeral Home 119 W. Cam-Wyo Ave. Wyoming, DE 19	
Physician	2		pproximate Interval etween Onset and
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Chronic Alcohol Abuse Due to (or as a consequence of):	Death
	aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	
executed an and al-transit	an/Medical Exa	events resulting in death) Last Due to (or as a consequence of): d.	
50, te be ex sysician	ledic		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be execut within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - tra	Sici	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)	Year
P.O. Bees that the defigned by the	ᇍ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the call 1 Yes 2 No 3 Probably	
of Vital Records, ag Physician: The law require After this certificate has been signeral director, page 2 should b	Completed	24a. Was an 24b. Were autopsy autopsy prior to comple	
Rec The lificate l		performed? 1 ✓ Yes 2 No 1 ✓ Yes 25. Was case referred to medical 26. Place of Death (Check only one)	2 No
Vital Vision ysician directo	To Be	25. Was case referred to medical examiner? 1 Ves 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Other Nursing Home 5 Residence 6 Other: Scen	ne
on of value of the funeral	tion: T	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending	
Division pital or Attendi ours after death.	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Ro or Town, State)	oute Number, City
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner stated.	se(s)
F § F 8	\$	29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Da	ay, Year)
		O.C.M.E. July 19, 2010	
		30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
Sta Regist	-		
Regist	CIL	AUG 18 2010 Samuel A gardel	

			For State Registrar	State of	Marylan		artment of F rtificate of		Mental Hy	ygiene Reg. No 2) 0	25	840
	Dhuaisi		1. Decedent's Name (First, Mid-						2. Date of D Month	eath Day	Year	3. Time o	
	Physici /Medio		Lucille U. B	Surkhart-Mos	es				Ju1y	26	2010	1:15	A M
	Examir	ner	4a. Facility Name (If not instituti	ion, give street and numb	er)		4b. City, Town, o	r Location of Dea	th		ty of Death		
4			Renaissance 5. Social Security Number		Ann da	In at birdh da .		Spring If Under 24 Hrs	0 D-14D		ce Geo		F '
	Funeral Director		385-40-3820	1 M 2 F 7.		last birthday,	Months Days	Hours Min	. (Month, D		Cour		
			Usual Residence of Decedent						Sept.	5 1917	Penn	isylva	nıa
	yland		10a. State 10b. Count	ty	10c. Cit	ty, Town or L	ocation				1	0d. Inside (City Limits
	a-fsl	cţo	MD Princ	e Georges	S	ilver	Spring					1 ☐ Yes	2 X No
	or 28)ire	10e. Street and Number				10f. Zip Code			10g. Citizen o	f What Cour	ntry?	
	23a	la I	3160 Gracefiel	d #0G 3323			20904			United	d Stat	es	
	r dea	Funeral Director	11. Marital Status	12. Was Decede Armed Force	e <u>s?</u>	.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Specify Yes or N rto Rican, etc.)	lo- 14. Ra Bl	ace - Americ		
36	or i	by F	1 ☐ Never Married 2 ☐ Ma 3 🔀 Widowed 4 ☐ Divorce	If Yes, Give			1 □Yes 2 No	Specify:		Spec	cify:		
21215-0036	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show deal Evenana rust be notfied at	ed b		ent's Education	es:	16a Dece	dent's Usual Occup	agtion		16b. Kind of	Whi		.1.2
15	in 72 n "na	plet	(Specify only high	est grade completed)		i (Give	kind of work done DO NOT use retire	during most of wa	orking	lob. Rind of	Daomooom	MI	cniga
212	with giene r tha	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+) 4	Pri	mary Scho	ol Teach	er	Public	Schoo	ol Sys	tem
	al Hyg othe	Be C	17. Father's Name (First, Middle	e, Last)				18. Mother's Na	me (First, Middle	e, Maiden Surna	ame)		
/lar	uld be Wenta Irked Itic e	20	Andrew Upter	raff				Mary Lo	esel				
Maryland	2 sho and Is me	ľ	19a. Informant's Name/Relation	nship (Type. Print)			ng Address (Street			-			
	and ealth m 27		Geoffrey Burkh	nart, Son			Lincoln A	venue, I					
Baltimore,	ges 1 t of H If Itel		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation	3 ☐ Removal from Sta	1 /	Place of Dispo cemetery, cre	osition (Name of matory or other pla	ce)	Date	20c. Location	ı - City or Ta	wn, State	
ţ	t. Pacturent tant:		4 ☐ Donation 5 ☐ Other				oln Crema			Brent	wood,N	Maryla	nd
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Madoni Exporting to use to notified at once.		21. Signature of Funeral Service	e Licensee M	01463	5	2. Name and Addre		Simple T			250	
			23a Part 1 Entry to diverse	or complications that cause	sad the deat		040 Rockv				MD 208	Approxima	ıte.
	Dhusisian		23a. Part 1. Ent in the divease, shock, or heart failure. Listemediate Cause (Fin. 1							allest,		Interval Be Onset and	etween
	Physician /Medical		disease or con lion resulting in death)		onic (ctive Pul	monary D)isease			lear	
\mathbf{T}	Examiner			540 10 (6)	ao a oonooq	1401100 017.							
	70 =	je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in the cause of the cause)	Due to (or	as a conseq	uence of):							
	ransi	Examiner	triat iritiated everits	c								_	
90,	ate be executed hysician and he burial-transit	ĕ	resulting in death) Last	Due to (or	as a conseq	uence of):							
09289	ate hys	dical		d									
9 x	eath certific attending p for use as	Physician/Med	IF FEMALE:	23c. If yes, outco	me of pream	anov						-	
Вох	atten for us	cian	23b. Was decedent pregnant in the past 12 months?	1 Live birt	th 2 ☐ Feta nt at time of o	al death 3	☐ Ectopic pregnand ☐ Other (specify) _	У			Date of delive Month	ery Day	Year
O.	uires that the de signed by the d be detached	ysi	1 □ Yes 2 🖾 No 9 □ Unknown	9 Unknow		Jean 31							
G .	that ned b deta		Part II. Other significant condit	tions contributing to deat	h but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco use co	ntribute to ti	he cause of	death?
Records,	quires an sig uld be	ed by	Congestive He	eart Failure	2				1 🗆	Yes 2□No	3☐ Prof	bably 4 📮	Unknown
ပ္သ	aw requir is been s should I	Completed							24a. Wa:		o. Were auto		
Ä	: The law cate has I page 2 s	E O							perf	opsy formed? 2 🔀 No	prior to co death? 1 ☐ Yes	mpletion of	cause of
Vital	ilclan: Th certificate ector, pag	BeC	25. Was case referred to medic	al				26. Place of De	eath (Check only		10163	2 🗆 140	
of V	Physician: this certific al director, p		examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inp	atient 2 🗌	ER/Outpatie	nt 3 🗆 DOA Oth	er: 4X Nursing	Home 5 ☐ Res	sidence 6 🗆 0	ther (Speci	fy)	
	ding Ph h. After thi funeral	ü	27. Manner of Death 1 ★Natural 5 Pend	28a. Date of (Month,	Injury <i>Day, Year)</i>	28b. Time of Injury	f 28c. Inju	ry at k?	28d. Describe	how injury occi	ırred		
sio	Attending in death. ector: After by the funer	cati	2 Accident inves	tigation				Yes 2 □ No					
Division	I or Attendi after death. Director: /	Certification: To		mined 28e. Place of	Injury - At ho , etc. <i>(Specil</i>	ome, farm, st fy)	eet, factory, office			(Street and Nun own, State)	nber or Rura	al Route Nui	mber,
	To the Hospital or Attent within 24 hours after deatt to the Funeral Director: completely filled in by the	ပ္	29a. Certifier 1 X Certify	ing Physician: To the be	act of my kas	wlodgo dos	h accurred at the ti	mo data and alac	on and due to th	o course(s) and	mannar as	stated	
	24 hc 24 hc Fun etely	Medical		al Examiner: On the basi and manner	is of examina	ation and/or in	n occurred at the the	opinion, death occ	curred at the time	e, date and place	e, and due to	o the cause	(s)
	vithin vithin ompl	Me	29b. Signature and title o certifi				29c. Licens	se number		29d. Date sign	ned (Month,	Day, Year)	
	آگ ،) la	166			D240	035		7/26/	10		
	1>		30. Name and address of perso	n who completed cause of	of death (Iten	n 23a) (Type.							
			E Smachado 3		eld Ro	ad Sil	ver Spri	ng, MD 20	0904				
	Sta		31. Date filed (Month, Day, Year		istrar's Signa	ture far	del						
	Registr	ar	AUG 04	2010 Denku	n B	gar	S. A. CO						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death BLACKWAL Physician/ 0320 M 1 LLI Am 0 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospice of Chesapeake Anne Arundel Linthicum 8. Date of Birth Dec • 14, 1952 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 M 2 D F Days Hours Virginia 228-74-8980 Director 57 Usual Residence of Decedent 2 should be filed within 72 hours and and Mental Hygiene.

17 is marked other than "natural", or items 23a or 28a-f show arrestic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Prince Georges Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 20745 6482 Bock Road, Apt. 413 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces? Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced Black Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Body & Fender Auto Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Rena Sheppard William Thornton Blackwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
De, artment of Health an
Important: If item 27 is
any injury or other trau 6482 Bock Road, Apt. 413, Oxon Hill, MD Barbara Ann Blackwell, Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 8/4/2010 Catlett, VA Oak Shade Bapt. Ch. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ames Funeral Home, Inc. barriard O Amor 8914 Quarry Road, Manassas, VA 20110 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each fine. Interval Between Onset and Deat Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine rany, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to jor as a consequence on attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? After this certificate 2 🗌 No Yes 2 No 1 🗌 Yes **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 잍 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) thin 24 hours after death.

• the Funeral Director: After this ompleted filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural To the Hospital or Attending within 24 hours after death. 5 \square Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) within 2 29b. Signature and title of certifie 2010 Name and address of person who completed cause of death (Item 23a) (Type, Prince 23a) EFENSE

Registrar

State

445

ENTA

6

31. Date filed (Month, Day, Year)

			For State Registrar					l / Depa		t of H	lealth		lental Hy		20	10	25842
	Physicia Medic		1. Decedent's Name (First, N Evelyn Loui	.se	Bailey				T				2. Date of De Month August	3,			3. Time of Death 11:52 p M
4	Examin	er	4a. Facility Name (if not instit 10321 Summit			umber)				Town, or nsin (Location of the contract of th	of Death			4c. County Mon t	y of Death gome:	
Ī	Funeral Director		5. Social Security Number 214-30-2200	6. S	ex □ M 2 X I		-	t birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi	rth av, Yea	1919	9. Birth Court	place (State or Foreign ntry) ginia
	th with the Maryland ms 23a or 28a-f show must be notified at	tor	Usual Residence of Deceder 10a. Ştate 10b. Co MD	unty	qomery			Town or Lo									10d. Inside City Limits
	ne Mary or 28a-	Director	10e. Street and Number	MOIIC	gomery	′	Ken		10f. Zip	Code				10a.	Citizen of	What Cou	1 🗆 Yes 2 🖰 No
	with the s 23a c	Funeral	10321 Summi	t Av	enue				208					_	SA		,
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Married 2 ☐ 3 ☑ Widowed 4 ☐ Divo		Armed			- 1	Was Deced f Yes, spec 1 Yes				ecify Yes or No Rican, etc.)	-	Bla	ce - Ameri ck, White, Whit	
15-0	72 hou n "natu Tedica	Completed	(Specify only		ade complete			16a. Deced	dent's Usua kind of wor O NOT use	rk done d	ation uring mos	t of worki	ng	16b	. Kind of E	Business Ir	ndustry
212	within giene. er tha		Elementary/Seconday (0- 12	12)	College	(1-4 or 5+)			li Wo	·	r				Foo	d Se	rvice
Maryland	ld be filed Mental Hy arked oth atic event	To Be	17. Father's Name (First, Mid Luther Zin										e (First, Middle Will	, Maide	en Surnam	e)	
	nd 2 shou ealth and m 27 is m ner traum		19a. Informant's Name/Relate Patricia E.		,, .			159	35 Me	eadov			ad, Woo				
Restimore,	Page 1 au ment of H ant: If iter ury or oth		20a. Method of Disposition 1 Burial 2 Crema 4 Donation 5 Ott			om State	cer	ice of Dispo metery, cren Lawn	natory or o	ther place		Au 2	g. 5 010		Location	•	own, State MD
THE PERSON NAMED IN	permit. Depart Import any inj		21. Signature of Funeral Sen	. (See	کویر		22 F 5	Name an ranci 00 Ur	d Addres is J nive	s of Facility Col	lins Blv	Funera d. W, S	al E Silv	Home ver S	Inc. prin	g,MD 20901
	Physician/		23a. Part 1. Exter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	e, or com List only o	one cause on Ser	at caused the each line. Sis to (or as a co		Do not ente									Approximate Interval Between Onset and Death 3 days
	e be executed ysician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	{	b. Uri	inary to (or as a co	Trac	t Inf	ectio	on							
09.	ate be exi physician the burial	ical	Tooling in doarn case	L	d					·					_		
. Box 6876	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown		4 🔲 Pr	outcome of p ve Birth 2 D regnant at tir nknown	Fetal of	death 3	☐ Ectopic p ☐ Other (sp		у					ate of deliventh	very Day Year
s, P.O.	ires that th signed by d be detac	d by Pr	Part II. Other significant col Congestive F					-		-		l.					he cause of death?
Division of Vital Records,	rhe law requate has been bage 2 shoul	complete	Chronic C. I	iffi	cile I	nfect	ion						24a. Was auto perf 1 \(\sum \) Yes	DSV		Were auto prior to co death? 1 \(\sum \) Yes	opsy findings available ompletion of cause of
tal	ician: 1 certifica ector, p	Be	25. Was case referred to med examiner?	lical	Hospital:					26. Pla	ice of Dea		only one)				
n of Vi	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2.	cate: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 P 2 Accident In	ending vestigation	28a. Da	☐ Inpatient ite of injury onth, Day, Ye	2	R/Outpatier 8b. Time of injury		8c. Injury work	4 ⊔ No		me 5 Res 28d. Describe				y)
ivisio	l or Atten after deal Director: I in by the	Certificate:	3 Suicide 6 C	ould not betermined	28e. Pla	ice of Injury ilding, etc. (S		e, farm, str			,,,,		28f. Location (City or To			er or Rura	Il Route Number,
	e Hospita 24 hours e Funeral aleted fillec	Medical	(Check 2 Medi	cal Exam	iner: On the I	basis of exam	nination a	and/or inves	tigation, in r	my opinio	n, death o	curred at	d due to the cathe time, date the time, date	and pla	ice, and di	e to the ca	ause(s) and manner state
	To th within	~	29b. Signature and title of ce	rtifier	-				290	License	number			29d. I	Date signe		Day, Year)
	ン		30. Name and address of per Robert Trimk						,	Aveni	ie. K	ensi	ngton,	MD	2089	5	
•	Stat Registra	e	31. Date filed (Month, Day, Ye	ar)	37	Registrar's	Signatu		Med	., 5.11	,		3 20		_ 333		
					h - 2			. ,									

Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month Marcia в. Brewington Ju₁v 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Montgomery 1102 Tiffany Road 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral 6. Sex 8. Date of Birth Days 1 □ M 2 🛣 F Director 211-16-3701 1923 18, une Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. sant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director Silver Spring MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20904 United States 1102 Tiffany Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 3 Married 1 ☐ Yes If Yes, Give 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Divorced Year or Dates ed other than "natur event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Self Employed Social Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) عامل کے Health ar. * tem 27 is mar. * traumatic ev ပ္ Ruby Martin Sumner Bohee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2332 Ashboro Drive, Chevy Chase, MD Dana Brewington - daughter permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burjar 2 X Cremation 3 Removal from State Chesapeake Crematory | Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 7/21/10 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signature of Funeral Service Lice Wash., D.C. 20012 7400 Georgia Ave., N.W. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Failure to thrive Medical resulting in death) Due to (or as a consequence of) Examiner Dementia Sequentially list conditions, if any, leading to immediate causa. Enter Undarlying Examine Due to (or as a consequence of): that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Abdominal aortic aneurysm Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death 1 Yes 2 S Yes 2 X No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Physician: The law requires Hypertension Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of Non insulin dependent diabetes mellitus 24a. Was an autopsy performed? death? After this certificate I Yes 2 StNo 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 1 🔀 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by City or Town, State) | Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) July 19, 2010 10 D0044369 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Martha Kern MD 50 W. Edmonston Dr. Suite 403 Rockville, Md 20852

12:40 P ^M

9. Birthplace (State or Foreign

Black

Onset and Death

Day

2 🗌 No

Year

10d. Inside City Limits

1 X Yes 2 No

T11inois

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

62. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 24a per med cert 6907 978/10 dk State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 07/ /2010 18 Theresa May Ballou 7:10p Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Casey House Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min. 1 🗆 M 2 🔀 F Hours (Month, Day, Y 2/25/4 Country) 220-40-5022 67 Director Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "nature" any injury or other traumatic events. 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 😾 No Montgomery Gaithersburg MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral US 18622 Walkers Choice 20866 Rd 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rlack. White, etc. 1 Never Married 2 Married þ 1 Yes Specify: Black 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) 9th College (1-4 or 5+) Domestic Housekeeping Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Josephine Campbell Wallace Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Ballou/husband 6003 Magnolia Court, Lanham. MD 20760 20b. Place of Disposition (Name of cemetely, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Bural & Cremation 3 Removal from State 4 Donation 5 Other (Specify) 8/6/10 Ardent Crematory Hanover, MD 21. Sign wire of Funeral Service Lice 22. Name and Address of Facility Snowden Funeral Home 746 N.Washington St., Rockville, MD 20850 23a. Part 1. Enter the disease shock, or heart failure. e, or complica List only one ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition ovarian neo lasm Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate page Film I in anying Cause (Disease or iinjury iner Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Divísion of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Dav Year 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has funeral director, page 2 performed' this certificate 2 No 1 Yes Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Yes 2 🛭 No Other: ၉ hospice 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🖾 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After 1 X Natural 5 Pending injun 1 ☐ Yes 2 ☐ No ☐ Accident Investigation completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Kouarchou, Jocetyne D63748 July 19 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jocelyne Kouatchou, 201 East University Parkway, Baltimore, MD 21218 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 02

Registrar

AUG

AMEND of Maryland & Berff#27perME aG908 a10/15/2010 ws State of Maryland & Berartment of Health and Mental Flyglenes Reg. N 2010 25845 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 0136 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Novh, Day Year 920 214-38-0201 Maryland **Director** Usual Residence of Decedent 28a-f shov er than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland 1 Yes 2 X No Anne Arundel Annapolis 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 1951 Forest Dr. 21401 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: Black Completed 3 ₩ Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Anne Arundel Co. and Mental Hygiene. is marked other than College (1-4 or 5+) 6+ Elementary/Seconday (0-12) 12th Public Schools Educator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Garfield Campbell May Lambert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Helen Austin(Cousin) 12500 Clearwater Way Upper Marlboro, Baltimore, 20a. Method of Disposition 205 blace of Apapaseon (Sam Coedar 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Bluff Cemetery Annapolis, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Williame a Break sept Facility Sons Mortuary, P.A. 821 West St. Annapolis, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause Interval Between Immediate Cause (Final Physician/ Divator disease or condition resulting in death) Medical Examiner THOK CERTIFICATION DEPOTED BY WEDVEL EXAMINER Sequentially list across things Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Certificate: To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No
9 Unknown Month 23e. Did tobacco use contribute to the cause of death? HYPERTENSION, OSTEOPOROSIS 1 Yes 2 No 3 Probably 4 Unknown RESTRICTIVE LUNG DISEASE DUE tO SEVERE 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an autopsy KYPHOSCOLIOS is performe 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manger of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred getting 1 Natura. 2 X Accident Suicide 5 Pending 7042010 1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) HOME 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29d. Date signed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State of Marylar		artment of F tificate of D		Mental Hy	giene, Reg. No.	010	25846
Physicia	an/	1. Decedent's Name (First, Middle, Last)	D				2. Date of De		Year	3. Time of Death
Medi	cal	Carl Burchman 4a. Facility Name (if not institution, give str			4b. City, Town, or	I the of Dooth	August	Day 8	2010	7:50 A M
Examir	ner	49451 Bayne Road	oct and nambery		Ridge	Location of Death	ı		County of Death St. Mary •	
Funeral	Г	5. Social Security Number 6. Sex	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir	th	g. Birth	nplace (State or Foreign ntry)
Director		219-12-2731 Usual Residence of Decedent	88	Yrs.			July 21	, 1922		aryland
land show dat	ρ	10a. State 10b. County	10c. Cit	y, Town or Loc	cation					10d. Inside City Limits
Mary 28a-f otifie	irec	Maryland St. Mary'	s]	Ridge					1 Yes 2 No
th the 3aor tben	Funeral Director	10e. Street and Number			10f. Zip Code	580		10g. Citiz	en of What Cou USA	untry?
eath w	nne	49451 Bayne Road 11. Marital Status	2. Was Decedent Ever in U.		Vas Decedent of His	spanic Origin? (Sp	ecify Yes or No-	14	4, Race - Ameri	ican Indian,
fter de ', or it amine	by	1 ☐ Never Married 2X Married	Armed Forces? 1 █ Yes 2 ☐ No If Yes, Give	li li	Yes, specify Cubar	n, Mexican, Puerto	Rican, etc.)		Black, White	, etc.
D-UU30 ! hours after "natural", o dical Exam	Completed	3 Widowed 4 Divorced 15. Decedent's Educ	Year or Dates.						pecify: Whi	
A 10-	mple	(Specify only highest grade		(Give k	ent's Usual Occupa kind of work done d D NOT use retired)	uring most of wor	king	16b. Kin	d of Business II	ndustry
Vigiene /giene /giene /giene /giene /giene /giene		Elementary/Seconday (0-12)	College (1-4 of 5+)	Elec	trician			E	lectric	al
and be filed ental Hy ked ott	To Be	17. Father's Name (First, Middle, Last)				18. Mother's Nan Edith		Maiden Su	ırname)	
ould bod Men		Spencer M. Barnes 19a. Informant's Name/Relationship (Type	Print)	10b Mailin	g Address (Street a			ar City or T	own State Zin	Code)
d 2 sh alth ar alth ar 27 is		Vivian Marie Barnes/ Wi			Bayne Road,			20680	own, otato, zip	codsy
partition of e.) Maryliand Z I Z I 3-0030 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show myn injury or othef traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Re		Place of Dispos cemetery, crem	sition (Name of natory or other place	e)	Date	20c. Loc	ation - City or 1	Town, State
Dailtimor bermit. Page 1 Department of mportant: If if any injury or o	8	4 ☐ Donation 5 ☐ Other (Specify)			's Cemetery		st 113010	Ride		7
Dan permi Depar Impor any ir		21. Signature of Funeral Service Licenses	Garoline		. Name and Addres	s of Facility Mat P.O.	tingley - G Box 270 L	ardine eonard	r Funera. town, MD	Home, P.A. 20650
		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the deat		r the mode of dying	, such as cardiac	or respiratory a	rrest,		Approximate
Physician/	8 3	Immediate Cause (Final disease or condition	(i) m	unt					F	Interval Between Onset and Death
Medical Examiner		resulting in death)	Due to (or as a consequent	uence of):						
	ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	uence of):						
uted od ansit	ami	cause, Enter Underlying Cause (Disease or illingury that initiated events c.								
e exec sian ar urial-tr	a E	resulting in death) Last	Due to (or as a consequent	uence of):						
rade for executed cate be executed physician and s the burial-transit	edical Examiner	d.								
cttending p		IF FEMALE: 23b. Was decedent pregnant 23c	c. If yes, outcome of pregna		1			23	3d, Date of deli	very
decth he tte	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of a 9 ☐ Unknown		Ectopic pregnancy Other (specify)	/ 			Month	Day Year
or Attending Physician: The law requires that the death certificate be executed after death. Include the this certificate has been signed by the citending physician and in by the funeral director, page 2 should be detached or use as the burial-transit		g Unknown Part II. Other significant conditions control		sulting in the u	nderlying cause give	en in Part I.	23e Did t	obacco use	contribinte to	the cause of death?
signe d be c	d by		3	J			1 🗆			obably 4 🗆 Unknown
v requires the speed signer is should be a	olete						24a. Was		24b. Were auto	opsy findings available
Physician: The law r this certificate has are director, page 2 and director, page 2 are director, page 2 are director, page 2 are director, page 2 are director, page 2 are director, page 2 are director, page 2 are director, page 2 are director, page 2 are director, page 2 are director, page 2 are director, page 2 are director, page 2 are director, page 2 are director, page 2 are director, page 2 are director, page 2 are director, page 2 are director, page 2 are director, page 3 are direc	Completed						auto perfe 1 🗆 Yes	psy ormed?	prior to condeath? 1 ☐ Yes	ompletion of cause of
cian: ertifica ector, p	Be	25. Was case referred to medical examiner?	spital:			ce of Death (Chec		-		
Physi This c	<u>1</u>	1 Yes 2 To	1 Inpatient 2 28a. Date of injury	ER/Outpatien	t 3 DOA Othe	4 ☐ Nursing H	ome 5 R Pesi			ý)
nding tth. : After e fune	cate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	work?		28d. Describe	now injury c	occurred	
A Atteiner des rector by the	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify		et, factory, office		28f. Location (Number or Rum	al Route Number,
oital or urs aft			(1)			10				
To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completed filled in by the funeral direction of the funeral direction of the funeral directions.	Medical	(Check 2 Medical Examiner	an: To the best of my know : On the basis of examination Practioner: To the best of m	n and/or investi	igation, in my opinio	n, death occurred a	at the time, date a	and place, a	nd due to the ca	ause(s) and manner stated.
To th withir То the		OCh Signatura title of partifier		13	29c. License	number	so, and due to ti		signed (Month,	
		I Novel M.	Fulul	M	1	24178		8	19/10	
		30. Name and address of person who com	pleted cause of death (Item 5 Three Notch R		,	v1and 206	36			
RMR Sta	te	31. Date filed (Month. Day, Year)	32 Paietrar's Signa	ture		J 20110 200				
Registra		AUG 10 201	0 Serve	1. A.	arle					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Donald Byrd Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death led ical ICMICO TENIN SULA KegIONAL 50/186414 . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 220-42-9458 1 **X** M 2 □ F Months Days Hours 63 Director 05/03/194 Maryland Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits Maryland Wicomico Salisbury 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 320 Mill Pond Lane, Apt. 715 21804 USA hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ð 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: white 3 Divorced 4 Divorced Specify Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) supervisor construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fill Department of Health and Mental Important; If item 27 is marked of any injury or other traumatic eve ၉ Howard W. Byrd Jennie Butler 19a. Informant's Name/Relationship (Type, Print)
Karyl Byrd/spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Jown, State, Zip Code) 320 Mill Pond Lane, Apt. 715, Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 8/4/2010 Salisbury Crematory Salisbury, MD Signature of Funeral Service Licenses Thomas and Association Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Ph sician/ Onset and Death Cardianyoputh disease or condition 1 Medical resulting in death) Due to (or as a consequence of Examiner SHIOD Critical Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Examiner Due to foresid consequence of To the Hospital or Attending Physician: The law requires that the de: th certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ttending physician and completed filled in by the itnered inverted inverse, page 2 should be detached or use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Day Pregnant at time of death Month Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by COPD 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 욘 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar (Check

only one 29b. Signaty e and tille

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signat

100 E. Carrou

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

ST.

450447

29d. Date signed (Month. Day, Year,

SALISBURY Md 21801

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month & Physician/ Year 7:21A M Broadhurst Caroline Medical 4b. City, Town, or Location of Death scility Name (if not institution, give street and number) 4c. County of Death **Examiner** 9Ta WICOMICO If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Days 1 □ M 2 🛣 F 76 Months Hours Min. (Month, Day, Year) **Director** 082-26-0441 -20 - 33Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director 1 💢 Yes 2 🗌 No MD Wicomico Delmar 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code "natural", or items 23a 21875 100 E. Pine St. USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. Ş 1 Never Married 2 Married Yes 2X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white Completed 3 🕅 Widowed 4 🗌 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within nent of Health and Mental Hygiene. 12 Hospital Billing Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk. unk. unk. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tammy Broadhurst /Daug.-in-law Pine St., Delmar, MD Ε. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Crematory of Delmarva 8/3/10 4 Donation 5 Other (Specify) Delmar, DE Signature of Funderal Service Licensee 22. Name and Address of Facility Bounds Funeral Home 705 E. Main St., Salisbury, MD 21804 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, chock, or heart failure. List one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the a Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe Yes 2 N 1 Yes 2 😿 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗆 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 08-01-10 S o. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREGORIO BELLOSO, M.D.; 5302 CHINABERRY DR. SALISBURY, MD. M 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25849 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Michael Thomas Becker IIMedical Facility Name (if not institution, give street and number) Town, or Location of Death Examiner 4b. Citv. 4c. County of Death 0 DVMIC 6. Sex 1 M M 2 □ F 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months 156-64-6123 Hours New Tersey 1672971973 36 Director Usual Residence of Decedent or 28a-f show e notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Wicomico Delmar 1 XYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 "natural", or items 23a or dical Examiner must be Funeral 21875 24 East State Street, Apt. B USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or in any injury or other traumatic event, the Medical Examin once. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🛣 No If Yes, Give 1 Yes 2 No Specify: 21215-003 3 Divorced Specify: white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) collections collector Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Michael Thomas Becker Barbara Heuring 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod. 9369 Guy Ward Rd., Parsonsburg, MD 21849 Barbara Peak/mother Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 🏅 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 8/3/2010 Salisbury Crematory Salisbury, MD 4 Donation 5 Other (Specify) 21. Signa re of Funeral Serv e L e ee HNTTOWAY FOLFER HOME Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final ACOUIRRA DRPFICIENCY SUNDROWR Physician/ IMMUNE disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown 9 Unknown s been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2/ No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy has page 2 this certificate 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? 1 ☐ Yes 2 ☐ No Hospital HOSPICER ၉ 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After injury 1 Natural 5 \square Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation after death completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Funeral L Medical Fertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Carrying Nurse Practioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause is and manner as stated. (Check To the within 2 29b. Signature and title 29d. Date signed (Month, Day, Year) D8058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 130 Date filed (Month, Day, Year) AUG 0 4 2010 3. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 7,^D2,010 **Physician** AUG. JOYCE ANN CAVEY 6:50P /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** CHARLES 2279 WESTWOOD DRIVE WALDORF 8. Date of Birth 3 - 1 9 4 5 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign WASHI'ry), D.C. 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 □ M 2 🔀 F 213-46-6914 65 Yrs. Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show the Medical Examiner must be notified at CHARLES WALDORF 1 ☐ Yes 2 📉 No Director MD. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò U.S.A. 2279 WESTWOOD DRIVE 20601 items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2√□No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 X No Specify SpecifyWHITE ٥ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "any injury or other traumatic event, the Many injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) ENTREPRENEUR SELF EMPLOYED 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LEE ARCHER BARTON MILDRED OPHELIA VAUGHAN ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHELLE ETCHISON-DAUGHTER 12426 WHISPER CREEK CT. CHARLOTTE HALL, MD. 20c. Location - City or Town, State 20622 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date M Burial 2 ☐ Cremation 3 ☐ Removal from State CEDAR HILL CEMETERY 8-11-10 SUITLAND, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A.
LA PLATA, MD. 20646 M0.0479 21. Signature of Faneral Service Licensee nalules Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications to caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** C /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 25 No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed l 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ icate has been siç r, page 2 should b 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 25. Was case referred to medical examiner? 26 Place of Death (Check only one. Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2- No 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27, Mapner of Death 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 29a. Certifier 🗜 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

P.O. Box 68760.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2585 I Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month JULY hanock 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 54KESVILLE CARROLL Social Security Number If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 ፟M 2 □ F Months Hours Min (Month, Day, July 8 348-14-9441 Yrs. Director 86 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If tiem 27 is amarked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MDMontgomery Bethesda 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7001 Longwood Dr. 20817 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 1945 Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2K No Specify: White Specify: Completed 3 X Widowed 4 Divorced 1955 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Scientist Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Theodore Chanock Frances Schwartz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Stephen Chanock/ Son</u> Glen Rd. Potomac. MD 20854 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2x Cremation 3 Removal from State 4 ☐ Conation 5 ☐ Other (Specify) Baltimore Crematory 8/5/2010 Baltimore, MD 22. Name and Address of Facility Simple Tribute M01463 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or lieart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be exeçuted Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of has autopsy death? performe within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🔀 No Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending work 1 🔲 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

2

Registrar DHMH 17 Rev 7/2009

State

Medical

29a. Certifier

only one) 29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5. DANK CRNP.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 💢 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

COPPER RIDGE, 710 Object Rd, SYKESVILLE, Maryland

R100599

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Elizabeth (ecelio 17:17 OW 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Howard County General Hospital Columbia 8. Date of Birth (Month, Day, Year) April 2, 1922 5. Social Security Numbe If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛣 F D.C. Director 579-22-1733 88 Usual Residence of Decedent Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director District of 1 Yes 2 No Washington Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4514 Connecticut Avenue, NW, #108 20008 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes Yes No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc þ 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify: Specify: White Completed 3X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) 2 Irene Battenfield Charles Hayden 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4514 Connecticut Avenue, NW, #108, Washington, 19a. Informant's Name/Relationship (Type, Print) Maureen C. Hickson/Daughter Date 11, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Aug. 1 2010 1 X Burial 2 ☐ Cpep MD Veterans Cemetery 4 Donation 5 Other Cheltenham, MD Signature of Fune Al Serv 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Priysician, (ute disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☑ No Month Year Pregnant at time of death 1 Yes 2 Li 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Records, 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Division of Vital 26. Place of Death (Check only one) Be 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DOO 66 115 02 D Un. Columbia, RD

Registrar DHMH 17 Rev 7/2009

State

21040

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_ FOI	epartment of Health and Certificate of Death	Mental Hygien	2010 25052	
Decedent's Name (First, Middle, Last)				2. Date of Death	3. Time of Death	
Physicia Medi	cal	Jessie Rose Elsberry Clay			2010 Year 1700 p M	
Exami		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat		c. County of Death	
1		Holy Cross Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthd)	Silver Spring If Under 1 Year If Under 24 Hrs		Montgomery O Birthslage Otets or Femilies	
Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 🔀 F 73 Yr.	Months Days Hours Min.		9. Birthplace (State or Foreign Country) Wash., D.C.	
		Usual Residence of Decedent				
yland f sho ed at	햣	10a. State 10b. County 10c. City, Town o			10d. Inside City Limits	
e Mar 28a- notifie	jrec		arlboro	1	1 XYes 2 No	
ith the	ral	10e. Street and Newsber 14000 Acadia Lane #304	10f. Zip Code 20774	1 1	Citizen of What Country?	
ems ?	Funeral Director	11 Marital Status 12. Was Decedent Ever In U.S.	13. Was Decedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - American Indian,	
6 ter de or it	by F	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No	If Yes, specify Cuban, Mexican, Puer	o Rican, etc.)	Black, White, etc.	
Ural",	ted	3 X Widowed 4 □ Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2 X No Specify:		Specify: African American	
72 hou	ple	(Specify only highest grade completed) (G	ecedent's Usual Occupation live kind of work done during most of wo	rkina I	Kind of Business Industry Lince Georges County	
than	Completed	Elementary/Seconday (0-12) College (1-4 or 5+)	e. DO NOT use retired) Teacher		chool System	
Hygin ent, t	Be (17. Father's Name (First, Middle, Last)		me (First, Middle, Maide		
rlan I be fi Aental Irked tic ev	잍	Jesse Ernest Oliver Elsberry	Evelyn	Anna Parkei		
Baltimore, Maryland 21215-0036 Jennit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Jennit if item 27 is marked other than "natural", on my nigury or other traumatic event, the Medical Exam one.		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)				
nd 2 siealth			2 Village Green Te			
Ore Je 1a t of H if ite or otl		1 X Burial 2 Cremation 3 Removal from State cemetery,	isposition (Name of crematory or other place)		Location - City or Town, State	
timent rtmen rtant		4 El Boriation 9 El Other (opecin))			elphi, MD eral Services, Inc.	
Baltimore, Maryland 21215-0036 Jemit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any nighty or other traumatic event, the Medical Examiner must be notified at one.		21. Signature of Funeral Service Licensee	7400 Georgia Ave.,			
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between				
Immediate Cause (Final disease or condition Pleural Effusion			n		Onset and Death	
Medical Examiner		resulting in death) Due to (or as a consequence of)				
	je L	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
ted d ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury				
execu an and rial-tra	Ä	that initiated events resulting in death) Last C. Due to (or as a consequence of)				
'60 ate be executed ohysician and the burial-transit	dical	d				
387 nrtifica ling p	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy				
Box 687 death certifica the attending p	cian	in the past 12 months?	3 Ectopic pregnancy 5 Other (specify)	,	23d. Date of delivery Month Day Year	
s, P.O. Bc es that the dea signed by the a	Jysic	1 Yes 2 X No 9 Unknown	o z otror (specify)			
P.O. that the ned by t		Part II. Other significant conditions contributing to death but not resulting in		23e. Did tobacco	o use contribute to the cause of death?	
dS, luires an sign	Completed by	Coronary Artery Disease, End Stage Renal Diseas		1 🗆 Yes	2 No 3 Probably 4 🔀 Unknown	
cords, w requires to been sig	plet			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of	
Reco	l m			performed		
ctor, I	Be	25. Was case referred to medical examiner?	26. Place of Death (Che	eck only one)		
hysic physic this c	Certificate: To				me 5 Residence 6 Other (Specify)	
In Of ding F. After funer		1 X Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be				
SiO Attender r deat cctor:	ΙĔ			28f. Location (Street and Number or Rural Route Number,		
Division of Vital Records, tal or Attending Physician: The law requires is after death. In Director: After this certificate has been signed in by the funeral director, page 2 should be		4 Homicide determined building, etc. (Specify)			City or Town, State)	
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
To the vithin To the somple	Σ	only one) 3 ☐ Certifying Nurse Practioner: To the best of my knowled 29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)	
			D625-71	Ju:	ly 20, 2010	
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sarah Bromeland, M.D. 1500 Forest Glen Road, Silver Spring, MD 20910				
Sta	ate	31. Date filed (Month, Day, Year) 72. Registrar's Signature		- 0-		
Regist		AUG 02 2010 Centra B. A	arked.			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 25854 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 8 700 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Annapolis 2501 Painter Court 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Min. (Month, Day, Hours Yrs 202-26-1970 Director Pennsylvania 76 26 - 1934Usual Residence of Decedent ir than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 Yes 2XX No Maryland Anne Arundel Annapolis 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21401 USA 2501 Painter Court 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. δ 1 Never Married 2 Married Yes 2 X No 1 ☐ Yes 2 🗓 No Specify If Yes, Give Year or Dates. Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working should be filed within 72 and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Homemaker Home traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Dolly Dougher Richard Kilhullen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tracence. Rockville, MD 20853 J. Daniel Connelly/ Son 16721 Cutlass Dr.. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 8/4/10 Clinton, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signatu 2973 Solomons Island Rd. Edgewater 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Opset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Comenting Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Examir signed by the attending physician and defached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 menths?

1 Yes 2 No Month Day Year 1 Yes 2 Unknown 9 🗀 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been si funeral director, page 2 should to 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 1 🗌 Yes the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: I or Attending Fafter death. 1 Natural 2 Accident 5 Pending 1 Yes 2 🗌 No Investigation Director: Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by ☐ Homicide determined Hospital 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signat 29d. Date signed (Month; Day, Year)

CH5 State

Baltimore, Maryland 21215-0036

P.O. Box 68760

Records,

Division of Vital

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ JULY 4:45 P ARNETT 2010 ROBERT CUMMINGS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1515 GOULD DRIVE PRINCE GEORGES DISTRICT HEIGHTS If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 XM 2 □ F Months 49 11**"/"2"0"/"1**"9**"6"**0 NORTH^{ry)}CAROLINA 244-17-5147 Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10h County 10d. Inside City Limits 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 X Yes 2 No PRINCE GEORGES DISTRICT HEIGHTS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1515 GOULD DRIVE 20747 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2 X No Specify. 3 Widowed 4 X Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) **SMITHSONIAN** MECHANICAL ENGINEER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ρ ERNEST LELAND CUMMINGS YVONNE TINSLEY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 537 EILERS ST., NORFOLK, VA 23505 ANTWONE MCWHIRTER/ BROTHER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State MD. VETERANS CEMETERY: 08/05/2010 CHELTENHAM, MARYLAND 4 Donation 5 Other (Specify) 22. Name and Address of Facility JOHNSON & JENKINS FUNERAL HOME Signature of Funeral Service Lidensee 716 KENNEDY ST. NW, WASHINGTON, DC 20011 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RECTAL CANCER Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying sician and burial-transit Cause (Disease or linjury that initiated events or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 ☐ Ectopic pregnancy
☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death the g Unknown detached g Unknown Division of Vital Records, P.O. cate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 \(\Delta\) No prior to completion of cause of death? 1 Yes 2 No certificate funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 2 🔀 No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 5 K Residence 6 Other (Specify, မ this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural (Month, Day, Year) work? injury 5 Pending To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fur М Investigation 2 Accident ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Jurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the p 3 Certifying Nurse Practions only one) 29d. Date signed (Month, Day, Year) 29b. Signature and 29c. License numbe 07 0/1 person who completed cause of death (Item 23a) (Type, Print) DR. IVAN ZAMA M.D. 9200 BASIL COURT SUITE 200, LARGO, MD 20774 31. Date filed (Month, Day, Year 32. Registra 's Signa State AUG 0 3 2010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. No ? Certificate of Death 3. Time of Death 2.304 M 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Anne Arundel Medical Center Anne Arundel Annapolis Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign Funeral 1 🗶 M 2 🗆 F Months Hours Min (Month, Da 212-24-4544 Yrs Director Ohio Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d, Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Funeral Director Examiner must be notified 1X Yes 2 □ No MD Charles Waldorf 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 23a United States 3863 Pine Cone Circle 20602 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 0 Completed by 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates Specify: "natural", 3 X Widowed 4 □ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of the and Mental Hygiene.

27 is marked other than raumatic event, the M Elementary/Seconday (0-12) College (1-4 or 5+) Crane Operator Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Bruce A. Cox, Sr Effie Chapel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce. Sandra L. Hendricks/ Daughter 3863 Pine Cone Circle Waldorf, MD 20602 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 🕅 Burial 2 □ Cremation 3 □ Removal from State Lincoln Cemetery 08/03/2010 4 Donation 5 Other (Specify) Brentwood, MD 21. Signature of Furleral Services Lice 22. Name and Address of Facility Ft. Lincoln Funeral Home 3401 Bladensburg Rd. Brentwood, MD 20722 23a. Part 1. Enter the disease, or complications that our shock, or heart failure. List or ly one cause, n each ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final onset and Death Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner physician and the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Certificate: To Be Completed by Physician/Medical the Hospital or Attending Physician: The law lequires that the death certificate be Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death 5 Other (specify) signed by the at d be detached for 9 Unknown P.O. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Denpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 27. Manner of Death funeral 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: At Accident 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 😕 e<mark>rtifying Physician:</mark> To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сопретер Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practionen To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check or by or all 29b. Signature and title of certifie 29c. License number

CR 20

DHMH 17 Rev 7/2009

Registrar

Date filed (Month, Day, Year)

AUG n

32. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 25857 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Year July 6:09 Ам Jerry Wayne Dingess 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Rockville Shady Grove Hospital Montgomery 8. Date of Birth (Month, Day, Year) Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Country) 1 X M 2 □ F Months Days Hours Min. Director 64 232-74-5230 1946 West Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director Gaithersburg 1 Yes 2 No MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20878 United States 12800 Tern Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? 1 ☐ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Give Vietnam Year or Dates. White 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Auditor Dept. of Defense Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Dingess Ona Dell Bell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12800 Tern Drive, Gaithersburg, MD 20878 Sue Dingess/ Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory 8/6/2010 Brentwood, MD 21. Signature of Fungral Service Licensee 22. Name and Address of Facility M01463 Simple Tribute 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. Enter the disea shock, or heart failure. Immediate Cause (Final e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death List only one cause on each line. Physician effusion malignant oleura disease or condition resulting in death) nknown Medical Due to (or a consequence of): **Examiner** pan creatic cancer unknown Sequentially list conditions, Je to (or as a consequence of): thany leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the recompleted filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Yes 2 X No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 K Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Examiner: On the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie orly one Certifying Nurse Practioner: To the best of my knowledge, deat id at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) A July D0062999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Montrose Rd., Rockville, Md. 20852 Donne

DHMH 17 Rev 7/2009

Registrar

31. Date filed Month, Day, Year)

AUG 04 2010

Maryland 21215-0036

Baltimore,

Division of Vital Records, P.O. Box 68760

LERRY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar 25858 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 7 Physician/ 1215 PM ro Medical Facility Name (if not institution, give street and number) 4b, City, Town, or L 4c. County of Death Examiner Medical MNE MUNEL ntek Glen Sex 1XXM 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Month, Day, Year 277/1949 Country) 217-50-9915 61 MD Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If fine 77 is marked other than "natural" ~ 3 any injury or other transmarks. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Anne Arundel 1 Yes X No MD Severn 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 8155 Walton Rd. 21144 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No þ 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White If Yes, Give Year or Dates Specify: 3 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Commercial Construct<u>ion</u> Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Troy E. Daff Sr. Beulah Perkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Mae Daff Wife 8155 Walton Rd. Severn, MD 21144 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Eurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 8/3/2010 Epiphany Cemetery Odenton, MD 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Fund | Service Lice Daw Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_ician/ disease or condition Medical resulting in death) Due to (or as a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnam
Unknown 5 Other (specify) Pregnant at time of death page 2 should be detached signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy within 24 hours affer death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page 1 Yes 2 No Yes 2 25. Was case referred to medica 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 2 No 1 Tyes 1 Inpatient 2 FR/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred iniury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29b. Signature a e of certific 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

30. Name and addres

Somie Ker 31. Date filed (Month, Day, Year)

AUG 03 2010

Medical Centers

son who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. For State Registrar 25859 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 17AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Cherry Lane Nursing Home (Hospice) Prince George's Laure1 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 1/27/192^{Year)} Kinston, NC Director 246-26-1921 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Prince George's Laurel 1y Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 14226 Summitt Lane 20708 United States death . Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No WW If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 2 □ No WW II þ 1 Never Married 2X Married 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. "natural", 3 Divorced Specify: Completed **Black** Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 1 and 2 should be filed within of Health and Mental Hygiene. Funeral Service Escort Fort Lincoln Cemetery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Abraham Dixon Bessie Coward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Theresa K. Dixon (Wife</u> .4226 Summitt Lane Laurel, MD 20708 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page 1 a Department of I Important: If ite any injury or ot XBurial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 8/5/2010 Brentwood, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home Signature of Funer Solvice Licensee quite Brentwood, MD 20722 3401 Bladensburg Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): death certificate be executed and -tran that initiated events Due to (or as a consequence of): resulting in death) Last physician a s the burial-1 Physician/Medical Box 68760 33 IF FEMALE: ase 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months? Po Month Day Year Pregnant at time of death 5 Other (specify) 2 No ed by the a detached t 9 Unknown 9 I Unknown Division of Vital Records, P.O. s been signed b should be deta Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Fibrillation 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a, Was an page 2 has To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate home of the funeral Director, page completed filed in by the funeral director, page Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 4 Nursing Home 5 Residence 6 Other (Specify ည 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural
Accident
Suicide 5 Pending injury work? 1 ☐ Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29d. Date signed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 25860 Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Month Physician/ 0805 M rgare Medical 4a. Facility Name of not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Annapolis Anne Arundel Anne Arundel Medical Center 8. Date of Birth March 7, 1939 Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 1 □ M 2 🖔 F Min. Hours Washington, DC Director 214-38-2237 71 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. ant. If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at. ury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tyes 2 No Anne Arundel Edgewater Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1712 Shadyside Drive 21037 USA . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🖾 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. δ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 7th Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Mildred Covey Charles Irving Buechling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert C. Estep/ Husband 1712 Shadyside Drive, Edgewater, MD 21037 Department of Health Important; If item 27 any injury or other the 20a. Method of Disposition 20b, Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State Kalas Crematory 8/6/10 Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility $\,$ George $\,$ P. $\,$ Kalas $\,$ Funeral $\,$ Home $\,$ 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final a Had Physician/ Heart disease or condition hour Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: *23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months? Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 🗓 No 1 🗌 Yes ျ 1 Inpatient 2 ER/Outpatient 3 X DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 👺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signa 2010 on who completed cause of death (Item 23a) (Type, Print) baum My State

DHMH 17 Rev 7/2009

Registrar

03

		for State of N		artment of Health	and Mental H	ygiene	10 25861						
		1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death											
Physic		Ina Agatha Camer	on Espeut		Month July	Day	Year 2010 12:45 P.M						
Med Exami		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of			ty of Death						
		12308 Featherwood Drive;		Silver Spri			ntgomery						
Funera Directo		217-70-7812 1 M 2 🔼 F	ge (In yrs. last birthday) 78 Yrs.	If Under 1 Year If Under Months Days Hours	Min. 8. Date of B Month, E Febru	oay, Year 9,	9. Birthplace (State or Foreign Country) Clarendon, Jamaic						
ind show at	ا ا	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	eation	·		10d. Inside City Limits						
/laryla 8a-f s tified	Funeral Director	Maryland Montgomery	Silver	Spring			1 X Yes 2 □ No						
of the Na or 2 be no	ق	10e. Street and Number	-	10f. Zip Code		10g. Citizen of	f What Country?						
h with	ner	12308 Featherwood Drive;		20904			, West Indies						
Maryland 21215-0036 12 should be filed within 72 hours after death with the Maryland lith and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	2	11. Marital Status 1 □ Never Married 2 ■ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Armed Forces' 1 □ Yes 2 ■ If Yes, Give Year or Dates.	? I No	Vas Decedent of Hispanic Orig Yes, specify Cuban, Mexican Yes 2 No Specify:	gin? (Specify Yes or No , Puerto Rican, etc.)		ace - American Indian, ack, White, etc. fy: Black						
5-C 2 hou "natu	plet	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	ent's Usual Occupation aind of work done during most	of working	16b, Kind of	Business Industry						
121 thin 7 sne. than	Completed	Elementary/Seconday (0-12) College (1-4 or 6th grade	5+) life. DC	NOT use retired) Homemaker	3	Don	nestic						
d 2 Hygie other	B B	17. Father's Name (First, Middle, Last)			er's Name (First, Middle								
rland	은	William Cameron		Ma	udri Pin	nock	,						
ore, Marylance 1 and 2 should be file to f Health and Mental I if item 27 is marked or or other traumatic eve		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street and Numbe	r or Rural Route Numb	oer, City or Town,	State, Zip Code) 20782						
and 2: Health Tem 27		Lloyd Anthony Espeut (Son			reet;Apt.l		sville,Maryland						
Baltimore, permit. Page 1 and Department of Hea Important: If item any injury or othe		20a. Method of Disposition 1		sition (Name of natory or other place) speut Family (ug.28,2010 Cemetery) Claren	n - City or Town, State don, Jamaica, Indies						
Baltimc permit. Page Department Important: I any injury o		21. Signature of Funeral Service Uninsee					pany Morticians, nington,D.C.20011						
ate be executed Exammine physician and the burial-transit	Examiner	23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):											
'60 ate be ohysic the bi	edical	d											
Box 68 , death certific he attending ed for use as	Physician/Me		2 Fetal death 3 at time of death 5	Ectopic pregnancy Other (specify)			Date of delivery Month Day Year						
S, P.O. ires that the signed by t		Part II Other significant conditions contributing to death	but not resulting in the ur	nderlying cause given in Part I	COR	tobacco use cor	ntribute to the cause of death?						
Kecords, The law requires ate has been sig page 2 should b	Completed by	@ DIABETES M.	PLL 19 L)S VALVULAR	per	s an 24b opsy formed?	Were autopsy findings available prior to completion of cause of death? □ Yes 2 □ No						
cian:	Be (25. Was case referred to medical examiner?			h (Check only one)								
Physic this c	음		tient 2 ER/Outpatien		rsing Home 5 X Res								
ding I h. After funer	ate	1 Natural 5 Pending (Month, D	ay, Year) 286. Time or injury	28c. Injury at work? M 1 ☐ Yes 2 ☐	1	how injury occur	rred						
DIVISION OT VITAI al or Attending Physician: s after death. al Director: After this certific ad in by the funeral director,	Certificate:		jury - At home, farm, stre tc. (Specify)		28f. Location	(Street and Numi	ber or Rural Route Number,						
fospital A hours a funeral E	Medical (29a. Certifier 1 Certifying Physician: To the best of Check 2 Medical Examiner: On the basis of	of my knowledge, death o	ccured at the time, date and p	place, and due to the co	cause(s) and man	iner as stated.						
thin 2 the F	Me	only one) 3 Gertifying Nurse Practioner: To the				the cause(s) and n	manner as stated.						
F ≥ F 3		Moranawa A, IV	KANMANI	7 Da45	93	July	30 , 2010						
		30. Name and address of barred who completed Anal (definantes a Mar E) ^{nt)} 3331 Toledo Hyattsvillo									
Sta Regist		31. Date filed (Month, Day, Year) AUG 0 3 2010 Server > 32. Register	rar's Signature										

State of Maryland / Department of Health and Mental Hygienes 25862 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 10^{pay} 2010^{rear} **Physician** Ann Charlotte Foreman 8:00 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Calvert Prince Frederick Calvert County Nursing Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Jan. 20, 1937

9. Birthplace (State or Foreign Country)
New York 7. Age (In yrs. last birthday)
73 Yrs. 5. Social Security Number **Funeral** Hours Months Days 577-52-7824 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County ?7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the World at Event in a to mail to 1 Tyes 2X No St. Mary's Mechanicsville Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code United States 20659 30165 Cochise Court Funeral death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian, Black White, etc. 72 hours after 1 Never Married 2 X Married 1 □ Yes 2 □ No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify: Specify: White ğ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) e filed within 7 ial Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker At Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be fill Health and Mental Health and Mental Health and Mental Health Helen Rubis Charles Foldy ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert W. Foreman/Husband 30165 Cochise Ct., Mechanicsville, MD 20659 Health tem 27 i permit. Pages 1 and Department of Healt Important: If item 2: any injury or other t 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Aug. 18, 20a. Method of Disposition 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 2010 Maryland Veterans Cem! Cheltenham, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., CHANA! 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Cirrhosis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine that the death certificate be executed Due to (or as a consequence of) Box 68760, attending physician for use as the burial Physician/Medical the nse 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 2 No P.O. the 9 Unknown 9 Unknown signed by to be a detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Encepholopothy 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? Ajy'tes 24a. Was an autopsy page performed certificate 2 Mo 1 ☐ Yes 2 ☐ No 1 □ Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ After this To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After it completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 50653 eyun 8-11-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GYAN SURANA

DHMH 17 Rev 1/2001

State

Registrar

5851-

31. Date filed (Month, Day, Year)

Deale

AUG 13 2010

Rugal

Decile

Churchten

32. Pagistrar's Signature

10-05942

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

James Oliver Fisi	j	1- For State Registrar Certificate of Death Reg. No. 2010 25863								
Physicia Medical Examin		James Oliver Fish Month Day Year August 7, 2010								3. Time of Death 2054 hrs
		4a. Facility Name (if not institut Peninsula Regional		nber)	46	. City, Town, o Salisbury	or Location of De		4c. County of Di Wicomico	eath
Funeral Director		5. Social Security Number 040-30-5197	6. Sex 7	7. Age (In yrs. last	t birthday) Yrs.	If Under 1 Ye Months Da		C-	10 (MM/DD/YYYY) 9.3 3/1937	Birthplace (State or oreign R enn sylvania
any	ı	Usual Residence of Decedent 10a. State 10b. Count	•		own or Location					10d. Inside City Limits
ie Maryland or 28a-f show fied at once.	to	Maryland Wic	omico	Mar	rdela S	prings 10f. Zip Code		- 14	0g. Citizen of What 0	1 Yes 2 X No
the Mar 3a or 28s	Director	11699 Norri	s Twilley R	oad		21837	7	,	USA	Southery:
	Funeral		Married 12. Was Dece Armed For 1 X Yes	2 No	If Yes		an, Mexican, Pue	Specify Yes or No rto Rican, etc.)	14. Race - Al White, et Specify: W	
72 hours aft "natural"	eted by	15. Decedent's Education (Sp Elementary/Secondary (0-12	pecify only highest grade	completed) 1	6a. Decedent's	Usual Occupa	ation (Give kind one. DO NOT use r		16b. Kind of Busine	ess/Industry Whitney
-0036 I within giene. ther tha	Completed	12 17. Father's Name (First, Middl	e Last)		mechan	ic oper		me (First, Middle, I	Aircraft	
1215. I be filed ental Hy arked of	Bec	Charles James	Fish				Marjo	rie Howa	rd	
MD 2 12 should th and M 127 is m	۵	19a. Informant's Name/Relation Eleanore F. Ko		er		,			nber, City or Town, S Sbury, MD	21804
more, Pages I and nent of Heal ant: If item		20a Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other		n State cre	ace of Disposition of the Sbury	r place)		Date /10/2010	20c. Location - City Salisbu	
Balti permit. Departr Import injury		2 Signature 34 Signature	e Licensee	CFSP	²² Na HO 50	Teland Address 1 Oway 1 Snow	Funeral Hill Rd	Home Pro	ofessional bury, MD 2	Association 21804
Physician /Medical		23a. Part I. Enter the disease, of failure. List only one caus	or complications that cause on each line.	used the death. D	o not enter the	mode of dying	g, such as cardia	or respiratory arm	est, shock, or heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final diseas or condition resulting in death)		Monoxio	de FOIS	oning_				
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Caus (Disease or injury that initialed	C.							
outed nd nd ransit	Exal	events resulting in death) Last	Due to (or as a c							
60, tte be executed nysician and e burial - transit	Medical I	X UNPENDED		23a,27,2		er me g	908 10-1	19-10 vt	Lood Date of dell	
OX 687(eath certifical attending place as the		IF FEMALE: 3b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 U	the 1 Live birt	nt at time of death	2 Fetal	death 3	Ectopic preg	nancy	23d. Date of deli Month	very Day Year
that the d	면 문	Part II. Other significant cond			ulting in the und	derlying cause	given in Part I.			e to the cause of death?
ords, F								24a. Was	an 24b. Were	e autopsy findings available to completion of cause of
Reco The law leate has	Completed				-				rmed? death	1?
Vital Recysician: The his certificate director, page	å	25. Was case referred to medic examiner?	11 21 1	patient 2 🗸 El	R/Outpatient		e of Death (Chec	ck only one)	Residence 6 0	ther:
n of V ding Phy . After th	일 :::	1 ✓ Yes 2 No 27. Manner of Death 1 Natural 5 Pei	28a. Date of (Month, D	f Injury 2i Day,Year)	8b. Time of Inju	ary 28c. Inju	ury at Work? Yes 2 📉 No	28d. Describe	how injury occurred t inhaled	1awnmower
livisior I or Attend after death Director: d in by the	ertification	2 Accident Inv 3 Suicide 6 X Co	estigation uld not be 28e. Place	of Injury - At hom		factory, office		exhaus 28f. Location (S or Town, S	Street and Number or State) I1699	Rural Route Number, City
To the Hospita within 24 hours To the Funeral completely fille	ㅇㅏ	29a. Certifier 1 Certifying	Physician: To the best caminer: On the basis of	of my knowledge,		d at the time, d		nd due to the caus		stated.
To t with To t	Medical	29b. Signature and title of certification	and manner sta			29c, Licen			29d. Date signed (
		M4 C		217	>	0.0	.M.E.		August 8, 201	0
		30. Name and address of person Russell Alexander M	D. Assistant Me			enn Street	, Baltimore;	MD 21201		
Sta Registr	te ar	31. Date filed (MITE Day, Year	2010 Reg	istrar's Signature	down	1		2015		

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	State of Marylan		artment of F tificate of E		ivientai Hy		2010	25864
	Physicia	n/	Decedent's Name (First, Middle, Las Cora	t) Elizabeth		Fisher		2. Date of De Month	Da	y Year	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give			4b. City, Town, or	Location of Dea	Augus		2010 County of Deat	2:24 P M
	7	•	209 W. Church St	. #17		Hel	bron		V	Vicomico)
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, D	ay, Year)	Cod	thplace (State or Foreign untry)
	Director		214-44-7099 Usual Residence of Decedent	Λ 03	113.			March	3,19	947	MD
	/land f shov ed at	tor	10a. State 10b. County	i i	, Town or Loc						10d. Inside City Limits
	e Mar r 28a- notifie	Director	MD Wicomi 10e. Street and Number	co	Hebron	10f. Zip Code			10 0		1X Yes 2 No
	vith th	ral	209 W. Church St	. #17		21830)		USA	tizen of What Co 4	untry?
	leath v items er mu	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?		Vas Decedent of His Yes, specify Cubar	spanic Origin? (5	Specify Yes or No-		14. Race - Ame	
36	ould be filed within 72 hours after death with the Maryland Id Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	ρ	1 Never Married 2 Married X Widowed 4 Divorced	1 ☐ Yes 2 X No		Yes 2 No		to riidari, etc.)		Black, White Specify: whi	
8	nours natura ical E	Completed	15. Decedent's Ed	Year or Dates.	16a. Deced	lent's Usual Occupa	ation			(ind of Business	
215	iin 72 ie. han "r	dwo	(Specify only highest gra Elementary/Seconday (0-12)	de completed) Callege (1-4 or 5+)	life. Do	kind of work done d O NOT use retired)	-	_			,
2	d with tygier ther t	Be C	8 17. Father's Name (First, Middle, Last)		Certi	fied Nurs		istant me (First, Middle		ealth Ca	re
aŭ	ild be filed a Mental Hyg arked oth atic event,	일	unk.	Alberts	on		unk.	ime (First, ivildale	unk.		
Maryland 21215-0036	should and M is man		19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Mailin	g Address (Street a	and Number or R	ural Route Numb	er, City or	Town, State, Zip	o Code)
€	and 2 stealth		Lee Fisher, Jr.		·	Quantico	Rd. Heb				
Baltimore,	permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en		20a. Method of Disposition 1 ☐ Burial 2 【☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	emetery, cren	sition (Name of natory or other place		Date		ocation - City or	Town, State
Ħ	mit. Pasartme oortan injuny	1	21. Signature of Funeral Service Licens			of Delma . Name and Addres		3/10		Lmar, DE.	
m	any per		L) enis Tel	lis Backen	1 7	05 E. Mai	in St.,	Salisbu	cy. M		
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of	olications that caused the death ne bause on e.c. line.	n. Do not ente	r the mode of dying	g, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Pnysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Hear	P(men	<i>Q</i>				Oriset and Death
	Examiner			Due to (or as a consequ	M						
	n #	Examiner	Sequentially list conditions, many, reading to immediate cause. Enter Underlying	Due to for se a consequ	enes siy	cicnl					
	ecutec and transi	Exam	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as la consegu		sich					
0	r requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	edical		· CAI							
8760	ifficate ng phy as the		IF FEMALE:	<u> </u>							
89 x	th cert ttendir or use	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 Live Birth 2 Feta	Ideath 3		у			23d. Date of del Month	ivery Day Year
. Box	that the death certifined by the attending detached for use a	Physician/N	1 Yes 2 No 9 Unknow	4 ☐ Pregnant at time of d g ☐ Unknown	eath 5 L	Other (specify)				(HOILL)	Day Tour
9. O	that the ned by e deta	by Pi	Part II. Other significant conditions co	ontributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco u	use contribute to	the cause of death?
ds,	requires been sign	ted						1 🗆	Yes 2	3 □ Pi	robably 4 🗆 Unknown
Records,	: The law re cate has be , page 2 sh	Completed						24a. Was		24b. Were aut prior to death?	topsy findings available completion of cause of
<u> </u>	ician: The certificate rector, pag		25. Was case referred to medical			26 Pis	ace of Death (Ch	1 🗌 Yes		o 1 Yes	2 🗆 No
Vital	ysicia is cert direct	To Be	examiner? 1 🗆 Yes 2 No	Hospital:	ER/Outpatien	_ Tothe	r: _	Home 5 Res	idence 6		ify)
0	ing Ph (fter th uneral		27. Manner of Deal	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work	?	28d. Describe	how injury	y occurred	
Sion	uttendi death ctor: A y the f	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be		me. farm. stre		Yes 2 No	28f Location /	Street and	d Number or Ru	ral Route Number,
Division of	al or A s after Il Direct		4 Homicide determined	building, etc. (Specify,		,,,		City or To			ar rioute runnisen,
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	(Check 2 Medical Exami	sician: To the best of my knowledger: On the basis of examination	and/or invest	igation, in my opinio	n, death occurred	at the time, date	and place	e, and due to the	cause(s) and manner stated.
	o the l	ž	only one) 3 Certifying Nurs 29b. Signature and title of certifier	e Practioner: To the best of my	knowledge, o	leath occurred at the 29c. License		lace, and due to t		s) and manner as te signed (Month	
	F>F0		D() () () () ()	- 4-5-1C)	RII	2925		(8-37	U
	Day		30. Name and address of person who o	completed cause of death (Item	23a) (Type, P	rint) / 1 1 -	. 0 0	Pan	m	1210	1
	Stat	0	31. Date filed (Mosts, Day, Year) AUG 0 4 20	3/3/1)	We I	ruegia	U. L	100 /	110	NO	/
	Stat Registra	ır	/ AUG 0 4 20	10 themas &	7. A.	War.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 1 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 11 11:00 a GORDON AUGUST 2010 HARRY LEON 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 24025 Chestertown Rd. Chestertown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Aug 20 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Days Months 1[**X**M 2□ F Yrs. 1934 Delaware 75 217-30-8694 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Chestertown MD Kent 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Kent 21620 24025 Chestertown Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 1957

If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify: White Specify. 3

Widowed 4 □ Divorced Year or Dates: -1963 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Self-employed House Painter 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Catherine Lipscomb Merritt Gordon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)MD 21620 19a. Informant's Name/Relationship (Type, Print) 24025 Chestertown Rd. Chestertown Mary Katherine Gordon (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 8/14/10 Smyrna, DE. Kent Cremation * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Galena Funeral Home of Stephen L Schaech 21. Signature of Tuneral Service Literate M00510 118 West Cross St. Galena, MD. 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition metastatic colon resulting in death) Due to (or as a consequence of) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown monomy Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? 1 ☐ Yes 2 **N**IO 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tyes 27 No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 27. Manner of Death 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

/Medical **Examiner** nding physician and use as the burial-transit The law requires that the death certificate be executed P.O. Box 68760, the use as atten for u signed by i Records. certificate Division of Vital or Attending Physicien: this After

Physician

/Medical

Examiner

Funeral

Director

28e-f show

ö

items 23e death v

0

"natural",

Hygiene.

Pages 1 and 2 should be filed w tment of Health and Mental Hygie tent: if Item 27 is marked other ti jury or other treumatic event.

permit. Pages 1 Department of P Importent: if ite any injury or ot once.

Physician

Examiner

Physician/Medical

the Medical Examiner must be notified at

Directo

Funerai

þ

Completed

with the Maryland

filed within 72 hours after

21215-0036

Maryland

Baltimore,

after death. To the Hospitel
within 24 hours a
To the Funerel D

Registrar

(Check only one)

29b. Signature and title of certifier

30. Name and address of person wito completed cause of death (Item 23a) (Type, Print)

29c. License number 0051786 29d. Date signed (Month, Day, Year)

120 Speer Rd. Chestertown, MD. 21620

Ferguson, M.D. 32. Registra s Signa 31. Date filed (Month, Day, Year)

		_ 101	e Type or Pr AMEND I State of I	r int in Bl TEM#30p Vlaryland					opies tal Hyg	Are Leg	ble.	25866
		1 - State Registrar			Ce	rtificate of	Death		R	eg. No.		
		1. Decedent's Name (First, Middle,	Last)						Date of Deat Month		. Year	3. Time of Death
Physic /Med		Edwin M. Gos	shorn)8	02 ^{ay} 2	O Î [®] Ô ^r	9:45 p. M
Exami		4a. Facility Name (If not institution, 711 Rocky Fount				4b. City, Town, o Myersvi	11e			4c. Count	y of Death deric	
Funera Directo		5. Social Security Number 187–48–3275	5. Sex 1 M 2 ☐ F	Age (In yrs. las 52	t birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. 8. [Min. (Date of Birth Month, Day 10–23-	Year) -1957	Cou	place (State or Foreign ntry) nnsylvania
P. J.		Usual Residence of Decedent		10. 07.	T1-						1.	10d. Inside City Limits
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, in Marchal Eron, and injury or other traumatic event, in Marchal Eron, and injury or other traumatic event.	Director	10a. State 10b. County 10c Freder	cick	Myers								1ÃYes 2□No
or 28)ire	10e. Street and Number				10f. Zip Code			1	l0g. Citizen of		ntry?
th will		711 Rocky Founta	ain Drive			2	1773				USA	
ems ems	Funeral	11. Marital Status	12. Was Decede Armed Force	ent Ever in U.S. es?	13.	Was Decedent of H	lispanic Or an, Mexicai	igin? (Specify n, Puerto Rica	Yes or No- n, etc.) 14. Race - An Black, Wh			
ral", or it	þ	1 ☐ Never Married 2X Marrie 3 ☐ Widowed 4 ☐ Divorced		⊠ No		1 □Yes 2 X INo	Specify:			Speci	white	
72 hc	etec	15. Decedent's (Specify only highest	Education grade completed)		(Give	dent's Usual Occup kind of work done	during mos	st of working	П	16b. Kind of E	Business/Ir	ndustry
ithin re.	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	DO NOT use retire	d)			Dome	a	
ed w		12			Motor	r Vehicle		er's Name <i>(Fir</i>	ret Middle	Dept.		шу
be fill be fill dot	Be	17. Father's Name (First, Middle, La	ast)					McAll		Maideri Garria	moj	
y could	은	Paul Goshorn			401 14-77				al Route Number, City or Town, State, 2			in Codo)
12 sh than 7 Is n traun		19a. Informant's Name/Relationshi				Rocky Fou						21773
Healt Healt Healt Healt		Catherine Elsba	ch (w	rife)	ce of Disp	osition (Name of	1			20c. Location		
Pages ment of ant: If its ury or o		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Thomas L. Geisel Cremetatory 21. Signature of Funeral Service Licensee										rsburg, PA
Physician /Medica		23a, Part1. Enter the disease, or o shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	complications that cau nly one cause on eac a.	M01346 used the death. th line. use as a conseque	Do not en	homas L. 33 FAllin ter the mode of dyi	g Spr ng, such as	ring Ro	ad. Cl	hambers	sburg	Approximate Interval Between Onset and Death
Examine	. .	Sequentially list conditions,	b									
cuted od	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter University Cause (Disease or injury that initiated events	c.	Due to (or as a consequence of):								
te be executed ysician and e burial-transit		resulting in death) Last	Due to (or	as a conseque	ence of):							
riffica ng ph as th	Medi	IE EEN IE							-			
To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the tuneral director, page 2 should be detached for use as the t	/sician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		th 2 🗋 Fetal on the at time of dea	death 3	☐ Ectopic pregnan ☐ Other <i>(specify)</i> _	су				ate of deli Month	very Day Year
res that the signed by	by Phy	Part II. Other significant condition	ns contributing to deat	th but not result	ing in the u	underlying cause gi	ven in Part	I.		obacco use co		the cause of death?
requir	eted											
The law ate has be page 2 s	Completed								24a. Was a autop perfor	rmed?	prior to c death?	topsy findings available completion of cause of 2 No
cian: ertific ctor,	Be (25. Was case referred to medical examiner?						ce of Death (C	heck only o	ne)		
hysi this c				patient 2 E		all all box		lursing Home				cify)
ending Peath.	ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investige	ng (<i>Month, Ďay, Year</i>) Injury Work? igation M 1 ☐ Yes 2 ☐ No							now injury occu		
tal or Att s after de al Directo	Certification: To	3 ☐ Suicide 6 ☐ Could no determin	ne, farm, s	treet, factory, office		28f.	Location (S City or Tow	Street and Nur vn, State)	nber or Ru	ral Route Number,		
e Hospit n 24 hour e Funera	Medical (29a. Certifier 1 Certifying	Physician: To the becaminer: On the bas and manne	sis of examination	ledge, dea on and/or i	th occurred at the nvestigation, in my	ime, date a opinion, de	and place, and eath occurred a	due to the at the time,	cause(s) and date and place	manner as e, and due	s stated. to the cause(s)
To th withir To th comp	Me	29b. Signature and title of certifier	1.			29c. Licen	se number			29d. Date sigi		
		May	> May						70067691 08-09-10.			

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Goldstein Frederick Memorial Hospital 501 W. 7th St. Frederick, MD 21701

		_	For State Registrar	State o	of Maryla	-	artment of H tificate of L		_	giene Reg. N2 0	10	25867
			1. Decedent's Name (First, Middle	, Last)	-				2. Date of De	ath		3. Time of Death
	sicia: /ledic		NELS	SON C.	GRAY	JR.			AUGUS	$\Gamma_{\perp} \stackrel{\text{Day}}{1}, 2$	2010	6:40 A M
	amin		4a. Facility Name (if not institution,	give street and nun	nber)		4b. City, Town, or	Location of Death	n	4c. County	of Death	
			5503 HILL		T=			TLAND	T	PRINC		
Fun Dire			5. Social Security Number 258-66-9562	6. Sex 1 🛣 M 2 🗆 F	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		th 7,1946		place (State or Foreign try) NGIA
		ł	Usual Residence of Decedent		0.	+			TIAKOII	7,1940	GEC	NGIA
land	d at	ţoţ	10a. State 10b. County		10c. C	ity, Town or Lo	cation				1	0d. Inside City Limits
Mary 28a-1	otifie	Director	MD. PRINCE	GEORGES			SUITLAND					1 ☐ Yes 2 ☐ No
h the	pe n		10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cour	ntry?
th wit	must	Funeral	5503 HILL			0 140 1		0746	- '' No No.		.S.A.	
r dea	niner	by Fu	11. Marital Status1 ☐ Never Married 2 ☐ Marr	Armed Fo	edent Ever in U prces?	1	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puert	o Rican, etc.)		ce - Americ ck, White, e	
S afte	Exan	g þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Giv Year or Da	ve NoVII ates.	ET- 1	☐ Yes 2X No	Specify:		Specify	BLA	CK
Z1Z15-UU36 within 72 hours after death with the Maryland giene. ier than "natural", or items 23a or 28a-f show	event, the Medical	Completed		nt's Education st grade completed,		16a. Deced	lent's Usual Occup	ation	kina	16b. Kind of B		
Z1Z15-UU36 within 72 hours after giene. er than "natural", o	e Me	mo	Elementary/Seconday (0-12)	College (1		life. D	O NOT use retired)	-	Mily			_
Id X	f,	0	17. Father's Name (First, Middle, L	2] MAS	TER ELEC		(Fire & & & del - 11-		GOV'	Т.
Maryland 2 should be filed to the and Mental Hyge 27 is marked oth	c eve	흔	NELSON		GRAY SI	R.			ne (First, Middle, TTIE MA		e, CRARY	,
and Mind Mind Mind Mind Mind Mind Mind Mi	umat	İ	19a. Informant's Name/Relationsh		JIGIT D.		g Address (Street a					
d2si altha	er tra		BRENDA GRAY	/WIFE		5503	HILL W	AY, SUIT	LAND, MD	. 20746		,
Ore, of He	ŧ	1	20a. Method of Disposition 1 ☐ Burial 2 ☐XCremation			Place of Dispo	sition (Name of natory or other place		Date	20c. Location		wn, State
Page	only		4 Donation 5 Other (S		State		CREMATO		-2010	RIVE	RDALE	E, MD.
Laitimore, Marylar permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked	any in		21. Signature of Funeral Service	auful	MOO!	091 22 091 5	Name and Address Name 801 CLEV	ss of Facility FUNERAL ELAND AV	HOME & C	REMATOR	IUM,P MD. 2	.0737
	П		23a. Part 1. Enter the disease, or shock, or heart failure. List o	complications that	caused the dea							Approximate Interval Between
Friysic	ianı/	8 9	Immediate Cause (Final disease or condition			NEOPLAS	M, PERIT	ONEUM				Onset and Death
Med Exam			resulting in death)		(or as a consec							
		ē	Securitizity list conditions, if any, leading to immediate	b. Due to	(or as a consec	THENCE Of:						
ped .	usit	Examiner	cause. Enter Underlying Cause (Disease or iinjury	Suc is	(0) 43 4 00/1300	querioc oi).						
execu in and	ial-tra	Ĕ	that initiated events resulting in death) Last	C. Due to	(or as a consec	quence of):						
ate be executed physician and	ne bur	dical	,	d								
oo/ ertificat iding ph	e as the	ğ	IF FEMALE:						- 777			
BOX C death ce	or us	ian/	23b. Was decedent pregnant in the past 12 months?	1 Live	tcome of pregn Birth 2 Fet nant at time of	tal death 3	Ectopic pregnand Other (specify)	ey .			ate of delive onth	ery Day Year
. D .	ched 1	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unk		dealii 5 L	Other (specify)					,
that th	deta	by P	Part II. Other significant conditio	ns contributing to d	leath but not re	sulting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use cont	ribute to th	ne cause of death?
dS, quires	nld be	ed k							1 🗆	Yes 2 XNo	3 🗌 Prot	oably 4 🗆 Unknown
e cords, e law equires e has t een sig	2 8 10	ple							24a. Was			osy findings available mpletion of cause of
he la	t age	Completed							perfo	rmed?	death?	2 🗆 No
Of VILAI ng Physician: ter this certific	ector,	Be	25. Was case referred to medical examiner?	Hospital:			26. Pl	ace of Death (Che	ck only one)			
Phys this	ral di	<u>۱</u>	1 Yes 2 X No 27. Manner of Death	1 🗆 28a. Date	Inpatient 2	ER/Outpatier 28b. Time of	t 3 DOA 28c. Injun	4 L Nursing ⊦	lome 5 X Resid)
ding th.	e fune	cate	1 X Natural 5 Pending 2 Accident Investig	g (Mon	th, Day, Year)	injury	work		Zou. Describe i	ow injury occurr	eu	
DIVISION tal or Attendir s after death. al Director: Af	py ‡	Certificate:	3 Suicide 6 Could r	not be 28e. Place	e of Injury - At h		et, factory, office			Street and Numb	er or Rural	Route Number,
ital or urs aft	lled in								City or Tow			
DIVISION OF VITAL FECONDS, P.O. BOX 687 (To the Hospital or Attending Physician: he law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician.	Tpleted f	Medical	(Check 2 Medical E	Physician: To the bas xaminer: On the bas Nurse Practioner:	sis of examination	on and/or invest	igation, in my opinio	n, death occurred	at the time, date a	ind place, and du	e to the cau	use(s) and manner stated.
To t	Į.		29b. Signature and title of certifie	11.2			29c. License			29d. Date signe		
7			- 1/4	¥ 17 ×				70102		08-0	5-0	2010
0			30. Name and address of person v				rint) L CT. SU	TTF 200	TARCO	MD 207	74	
	State	е	31. Date filed (Month, Day, Year)		Registrar's Signa			11E ZUU,	LANGU,	ти» ZU/	<i>,</i> , <u>, , , , , , , , , , , , , , , , , , </u>	
Rec	gistra	r	AUG 04	2010 00	sur 1	a. 190	100					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25868 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ J_{u}^{Month} 31, 2010 Francis Levine Gist 12:30 p M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Country Care Farms Assisted Living Westminster Carrol] **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 1**℃** M 2 □ F Days Hours Nov 19, 1925 Maryland 84 Director 215-24-3704 Usual Residence of Decedent and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Baltimore MD Jarrettsville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21084 3543 Anderson Lane USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 Yes 2 No 1944 Black, White, etc. 1 Never Married 2 Married <u>۾</u> Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give 3 ₩ Widowed 4 □ Divorced Completed 1946 White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Owner/Operator Trucking Business 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be a Department of Health and Menta Important: If item 27 is marked Thomas Benjamin Gist Margaret Elizabeth Hughes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jarrettsville, MD Francis W. Gist 3543 Anderson Lane 21084 son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State any injury or 4 Donation 5 Other (Specify) Park Cemetery 8/4/2010 Smallwood, Maryland Signature of Furgeral Service Licenses 22. Name and Address of Facilitaritts Funeral Home & Chapel, PA 21157 Washington Rd. Westminster, MD 23a. Peru. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death letasta Statu Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) nding physician and use as the burial-transil that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s autopsy performed Yes 2 🗗 death? certificate 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 \square Nursing Home 5 \square Residence 6 \nearrow Other (Specify, 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA o the Hospital or Attending Plyin 24 hours after death.
o the Funeral Director: After the completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 29b. Signature and title of certifie 29d. Date signed (Month. Dav. Year) 1 52035 20/0 WJL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21157

5+1VA

Baltimore.

68760

Box (

P.O.

Records,

Division of Vital

State Registrar 31. Date filed (Month, Day, Year)

BINU

32. Registrar's Signature

Staren

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien U State
Registrar Certificate of Death Rea. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2010 Physician/ Marquerite Greeley 30 8:00 a July Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 1513 Windham Lane Silver Spring Montgomery 8. Date of Birth (Month, Day, Year) June 25, Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 F 012-03-2580 Director Louisiana 96 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland al Hygiene. 10d. Inside City Limits Director Maryland Montgomery Silver Spring 1 Tes 2 No 10e. Street and Number 10g. Citizen of What Country? 2402 Dexter Avenue Funeral 20902 USA Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Completed by 1 Never Married 2 Married ☐ Yes Yes, Give 2x No 3altimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White "natural", 3 Widowed 4 ☐ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jamillia Sawaya Charles Carson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7010 Freeport Street, Hyattsville, MD 20784 John J. Greeley/Son 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 😾 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Aug. 2010 Gate of Heaven Cemetery Silver Spring, Maryland 21. Signature of Funeral Service Licensee Francis Addess Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final Acute Myocardial Infarction Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Atherosclerotic Heart Disease 10 yrs. Sequentially list conditions, Due to (or as a consequence of) if any, Lading to him ediate cause. Enter Underlying Cause (Disease or linjury or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Year g Unknown signed by t Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diabetes Mellitus, Hypertension, Hyperlipidemia 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 🗌 Yes 2 No Yes 2XXN Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6X Other (Specify) Residence examiner?
1 Yes 2 (No မ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred After Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident within 24 hours after deat

To the Funeral Director:
completed filled in by the Suicide 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 10 29c. License numbe 29d. Date signed (Month, Day, Year) D09748 July 30, 2010 Z W5 for 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alan Weinstock, MD 10313 Georgia Avenue, Silver Spring, MD 20902

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 25870 State of Maryland / Department of Health and Mental Hygien State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ July 26. 2010 10:40 p M Mary Jane Grant Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Mon toomery Silver Spring 12811 Atherton Drive If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** (Month Day, Year) t. 10, 1917 Days 1 🗆 M 2 📭 Country) Arkansas 432-48-6351 92 Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State the Maryland Director 1 🗌 Yes 2 🏝 No Silver Spring Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral be filed within 72 hours after death with 20906 LISA 12811 Atherton Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Bace - American Indian. 11. Marital Status Black, White, etc. orces : 2 No WWII ģ 1 Never Married 2 Married 1 X Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify Specify White 3 Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) id Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Nursing 3 Registered Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Edward Henderson Carrie Elta Blackerby should is and Me 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 12811 Atherton Drive, Silver Spring, MD 20906 Dorothy Joanne Grant/Daughter Date 23, 20c. Location - City or Town, State 20a Method of Disposition 20h Place of Disposition (Name of cemetery, crematory or other place)
Arlington National
Cemetery Aug. 2010 1 Surial 2 Cremation 3 Removal from State Arlington, Virginia 4 Donation 5 Other (Specify 21. Signature of Funeral Service Francis Address ITTHE Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death Dec. 2009 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Congestive Heart Failure disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Sequentially list conditions, Examine Due to (or as a consequence or) n any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Yes 2 No ed by the a 9 🗌 Unknown 9 Unknown s been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 certificate has 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

To the within 2 20

> State Registrar

Medical

29a. Certifier

(Check

3 🗌

Mham Do, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

000 3600

29c. License number

WAShet

29d. Date signed (Month, Day, Year) 30/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ GRADY CHERYL Т. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** DOCTOR'S HOSPITAL LANHAM PRINCE GEORGE'S 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** JAN 17 Days Hours 1 □ M 2 🖳 F WASHINGTON, DC T948 579-64-3183 62 Director Usual Residence of Decedent than "natural", or items 23a or 28a-f shov he Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Directo Yes 2 No MD PRINCE GEORGE'S LANHAM 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9921 GREENBELT ROAD # 201 20706 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 0. permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir Completed by 1 Never Married 2 Married BLACK 1 ☐ Yes 2 X No 3 Widowed 4 X Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 1YR SENIOR CLERK PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WILBERT WALLACE U/K 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9921 GREENBELT ROAD #201 LANHAM, MARYLAND 20706 MICHAEL BELL/SON 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State MARYLAND NAT'L CEMETERY 8/3/2010 LAUREL, MARYLAND 4 Donation 5 Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME Signature of Funeral Service Licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death ARRYTHMIA CAPDIAC Physician/ disease or condition Medical resulting in death) **Examiner** FAILURE RESPIRATORY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events ENCEPHALOPATHY attending physician and for use as the burial-tran resulting in death) Last CHOLANGIO CARCINOMA Physician/Medical or Attending Physician: The law requires that the death certificate be TASTATIC Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed within 24 hours after death.

To the Funeral Director; After this certificate 1 🗆 Yes 2 🗆 No Yes 2 D 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 2 No Inpatient 2 -ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner_of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0064478 07-27-2010 Mehan. Road Suite 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ISEHATSION MEHARI 20769

Registrar

31. Date filed (Month, Day, Year)
AUG 0 3 2010

32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 8,_ 2010 Lorain Hanline August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Garrett Dennett Rd. Nursing Home 0akland 8. Date of Birth (Month, Day, 11/15/ 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Months Days Hours 1X M 2□ F 91 232-24-4144 Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10c, City, Town or Location 10d. Inside City Limits 10a. State 10b. County rand Mental Hygiene.
I smarked other than "natural", or items 23a or 28a-f show
is marked other than "natural", ar items 25a or 28a-f show
ranmatic event, the Medical Examiner must be notified at 1 ☐ Yes 🎾 No WVPreston Director Aurora 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22940 George Washington Hwy. 26705 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: ò 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Equipment Operator MA DOH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Martin Sylvester Hanline Anna Elizabeth Wotring 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ant; If item 27 is ury or other trains 22940 G.W. Hwy. Aurora, WV 26705 Mary Jane Hanline/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Injury or Department of Important; If any Injury of once. Aurora Cemetery 08/11/2010 Aurora, WV 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Hinkle Funeral Home, Inc. POBox 186 Davis, WV 26260 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician week disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Exactly confine Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Vear 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To After this 27. Manual of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred or Attending Natural 5 Pending investigation 1 Tes 2 □ No within 24 hours after death To the Funeral Director: 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide Hospital Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated.

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

AUG 182010

Johnson

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 311 N. 4th St.

32. Registrar's Signatur

015333

29d. Date signed (Month, Day, Year)

			1 _ State	of Maryland		artment of F ertificate of I		/lental Hy			0.50.50	
	_		Registrar 1. Decedent's Name (First, Middle, Last)			Timodic or i		2. Date of De	Reg. No	1-U-	3. Time of Death	
	Physicia		Harry Samuel Hayman					July 3	1, ^{Day}	Year	12:30 р м	
~	/Medic Examin		4a. Facility Name (If not institution, give street and	i number)		4b. City, Town, or	Location of Death	l		ty of Death		
j.		•	11106 Orleans Way			Ken	sington		Mont	gomery	<i>J</i>	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday	1	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Di	rth		place (State or Foreign	
	Director		489-18-8911 ¹ X M 2□	88	Yrs.	Wortins Days	Hours Will.		7, 1921		ssouri	
	and w		Usual Residence of Decedent 10a. State 10b. County	10c City	, Town or L	ocation				1	0d. Inside City Limits	
	faryk f sho	ō								Ι,	1 □ Yes 2 □ No	
	28a-	Director	Maryland Montgomery 10e. Street and Number	Ken	singt	On 10f. Zip Code			10g. Citizen o	f What Cour		
	with 3a or		11106 Orleans Way				0.5			What ood	M.y.	
	ns 2%	Funeral		Decedent Ever in U.S	3. 13.	Was Decedent of H If Yes, specify Cuba		ecify Yes or No	USA 0- 14. Ri	ace - Americ	can Indian,	
9	72 hours after death with the Maryland Inatural", or items 23a or 28a-f show draft Evan, incr. rust be rediffed at		Arme	d Forces? es 2 ☐ No , Give				Rican, etc.)	I	ack, White,		
03	ral", c	l by	3 ☐ Widowed 4 ☐ Divorced If Yes Year	, Give or Dates: WWII	era	1 □Yes 2 No	Specify:		Specify: White			
21215-0036	72 ho	Completed	15. Decedent's Education (Specify only highest grade complet	ed)	(Give	edent's Usual Occup	lurina most of work	16b. Kind of Business/Industry				
121	/ithin ine. han '	ᇤ		ge (1-4or 5+)	`life. CWO	DO NOT use retired)					
	Hygie Hygie ther t		12 17. Father's Name (First, Middle, Last)		CWO		18. Mother's Nam	. /Eirot Middla		oast G	uard	
and	buld be f Mental P arked ol atic eve	Be o	George Cecil Hayman				Hazel F	- '	e, Maluell Sullia	inej		
Maryland	hould Me mark	스	19a. Informant's Name/Relationship (Type. Print)		19b Maili	ing Address (Street a	and Number or Rui	ral Bouta Numb	ner City or Tow	n State Zir	Code)	
Z	nd 2 s lith ar 27 is r trau		Ann W. Hayman/Wife			06 Orleans			. ,		obde)	
ē,	f Healifem		20a. Method of Disposition	20b. PI	ace of Disp	osition (Name of matory or other place	, way, Re	Date	20c. Location		wn, State	
E O	Page: ent o nt: If ry or		1 Burial 2 D cremation 3 Removal fr 4 Donation 5 D Other (Specify)			matory or other place n National metery		5108,	Arlin	aton.	Virginia	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is infected. Event, and injury or other traumatic event, it is infected.		21. Signature Fineral Jerice Icense		2	2 Name and Address	e of Facility				<u>-</u>	
m	Depa Impo any is	7	1/2/7-P	^ _	1	rancis J. 500 Unive	Collins	Funera d. W.,	l Home Silver	Inc. Sprin	ng,MD 20901	
			23a. Parz 1. Enter the disease, or complications the shock, or heart failure. List only one cause of	at caused the death							Approximate Interval Between	
E	Physician		Immediate Course (Final	iration Pr	neumor	nia				24	Onset and Death	
	/Medical		resulting in death)	e to (or as a consequ								
	Examiner		Sequentially list conditions Dys p	hagia								
	en te	Examiner	cause. Enter Underlying	to (or as a consequ								
	be executed iician and burial-transit	хаг	that initiated events c	bral Vascu		Accident						
.09	physician the buria		Due	to (or as a conseque	ence on.							
68760,	ificate be exe g physician al as the burial-t	edical	d									
Вох	leath certifi attending for use as	Ž	IF FEMALE: 23c. If yes,	outcome of pregnar					23d. D	ate of delive	erv	
m.	The law requires that the death cert ate has been signed by the attending bage 2 should be detached for use a	Physician/M	in the past 12 months?	ive birth 2 Tetal regnant at time of de		☐ Ectopic pregnancy ☐ Other <i>(specify)</i>	<u> </u>		N	/lonth	Day Year	
Р.	t the by th tache	hys	9 ☐ Unknown 9 ☐ U	Inknown								
S,	w requires that the do been signed by the should be detached	by P	Part II. Other significant conditions contributing t	o death but not resul	lting in the u	ınderlying cause give	en in Part I.	23e. Did	tobacco use co	ntribute to th	he cause of death?	
ord	equire een si ould t							10	Yes 2 □ No	3 ☐ Prob	bably 4 [™] Unknown	
ecc	e law re has be e 2 sho	Completed						24a. Was		. Were auto	psy findings available mpletion of cause of	
Ξ.	: The I	Com						perfo	ormed?	death? 1 ☐ Yes	·	
/ita	ician: Th certificate ector, pag	Be (25. Was case referred to medical examiner?				26. Place of Deat					
=	hysic this c		1 ☐ Yes 2 ☑ No Hospital:	☐ Inpatient 2 ☐ E			4 🗀 Nursing Ho	me 💆 Res	idence 6 □ C	ther (Specif	у)	
Ž	ing P	ion:	1 ☑Natural 5 ☐ Pending (A	ate of Injury Month, Day, Year)	28b. Time o Injury	Work		28d. Describe	how injury occu	ırred		
Sic	ttend death tor: ,	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				/es 2□No					
Division of Vital Records,	or A after of Direct in by	Certification: To	determined 200.11	lace of Injury - At hor uilding, etc. (Specify,	ne, iarm, sti	reet, ractory, office		City or To	wn, State)	iber or Hura	al Route Number,	
	spital ours neral filled		29a. Certifier 1 X Certifying Physician: To	the best of my know	vledge, deat	th occurred at the tin	ne, date and place	and due to the	cause(s) and	manner as s	stated.	
	e Hoo 1 24 h e Fur iletely	Medical	(Check only 2 Medical Examiner: On the	ne basis of examinati nanner stated.	ion and/or ir	nvestigation, in my o	oinion, death occur	red at the time,	, date and place	, and due to	the cause(s)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, p.	Me	29b. Signature and title of certifier			29c. License	number		29d. Date sign	ed (Month,	Day, Year)	
	inti) /smm/	m		D35	579		Augus	t 2,	2010	
	10		30. Name and address of person who completed of	ause of death (Item	23a) (Type,	Print)			J W			
			Susan J. Miller, MD	8218 Wis	consi	n Avenue,	#305, Be	ethesda	, MD 20	814		
	Stat Registra	-	31. Date filed (Month, Day, Year) AUG 04 2010	2 Registrar's Signatu	Jac.	while						

DHMH 17 Rev 1/2001

			For	State of Mary	land / Dep	artment of l	Health a	ınd Mental Hy	giene				
		1 - State Registra/MEND#8perFH, 8/13/10, BWW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death											
	Physicia	in/		,				2. Date of De Month	eath Day Ye	3. Time of Death			
ar	Medic Examin		Mary Barb 4a. Facility Name (if not institution, give		ond	4b. City, Town, o	or Location of	July	29 201 4c. County of [
	Examin	er	Holy Cross Ho			Silve			Montgo				
	Funeral		5. Social Security Number 6. Se	7. Age (In)	rs. last birthday)	If Under 1 Year Months Days		4 Hrs. 8 Date of Bir	7-11-1935 9.	Birthplace (State or Foreign			
	Director		577-50-8573 I	□м 2х□ г 75	Yrs.	WOITINS Days	Hours	Min. Month, Pa	1935	Big.			
	ind show at	 5	Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or L	ocation				10d. Inside City Limits			
	Aaryla 8a-f s tified	Director	MD Prince	Georges F	t. Was	hington				1 🔀 Yes 2 □ No			
	the N		10e. Street and Number	deorgeb, r	c. nab	10f. Zip Code			10g. Citizen of Wha	t Country?			
	h with	Funeral	7615 Lanham L	ane		2074			USA				
	r item		11. Marital Status	12. Was Decedent Ever in Armed Forces?	1 U.S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origi an, Mexican,	in? (Specify Yes or No- Puerto Rican, etc.)	14. Race - A Black, V	American Indian, Vhite, etc.			
920	s after al", o Exam	d by	1 ☐ Never Married 2√☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates.		1 🗌 Yes 2 No	Specify:		Specify:	Black			
0-10	hours natur dical	Be Completed	15. Decedent's Ed	ducation		edent's Usual Occup			16b. Kind of Busine	ess Industry			
21	nin 72 ne. han " e Mec	omp	(Specify only highest gra Elementary/Seconday (0-12)	College (1-4 or 5+)		kind of work done OO NOT use retired,		ot working		ost Office			
72	d with	3e C	1. Father's Name (First, Middle, Last)		Po	stal Wo			Federa	I Govt.			
anc	be file ental H ked o c eve	To E							ame (First, Middle, Maiden Sumame) Lancaster				
ary.	nd Me mark mark		Gerald Costley 19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Mail	ina Address (Street		or Rural Route Number		. Zip Code)			
Š	d 2 st alth a n 27 is er tra		Tara Hammond /D	aughter	7615	Lanham	Lane	Ft. Was	hington,	MD 20744			
Baltimore, Maryland 21215-0036	Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition 1 □ Burial 2 ▼ Cremation 3 □			osition (Name of matory or other pla	ce)	Date	20c. Location - City				
<u>H</u>	. Page ment tant: I jury o		4 Donation 5 Other (Specific		iverda	le Park	8	7 4 2010					
1	permit. Page Department Important: I any injury or		21. Signature of Fun Val Service Licens	Funeral	Home, Inc.								
_ <i>t</i>		, 12	23a. Part 1. Enter the disease, or comp	cc02	13		_			on,DC 20011			
	h sician/		shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.				araido or roopii atory ar		Approximate Interval Between Onset and Death			
	Medical		disease or condition resulting in death)	a. Congest Due to (1 as a con	ive Hea	art Fail	ure			1			
	Examiner	L	Sequentially list conditions	Pulmona									
-	D #	nine	Sequentially list conditions, cause. Enter Underlying	Dunito (or es a con	sechence og).								
	ecuter and -trans	Examiner	Cause (Disease or linjury that initiated events resulting in death) Last	c. End Sta	ge Ren	al Disea	ise	. <u>-</u>					
	To the Vispital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Which is the fare death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.	dical F											
3760	ficate g phys	/ledi		d	-					1			
36 36	endin endin	an/N	23b. Was decedent pregnant	23c. If yes, outcome of pre 1 ☐ Live Birth 2 ☐		Ectopic pregnan	CV		23d. Date of	delivery			
Bo	death he att	Physician/Med	in the past 12 months? 1 ☐ Yes ② No 9 ☐ Unknown	4 ☐ Pregnant at time 9 ☐ Unknown		Other (specify)	-,		Month	Day Year			
o.	at the d by t detach		Part II. Other significant conditions co	ontributing to death but no	t resulting in the	underlying cause gi	ven in Part I.	23e. Did t	obacco use contribut	e to the cause of death?			
S, T	ires th signe d be c	d by				, , ,				Probably 4 🛭 Unknown			
ord	required peen	lete						24a. Was	an 24b. Were	autopsy findings available			
ec.	he law te has age 2	Completed						auto	psy prior prmed? deat	to completion of cause of h?			
a	ian: T rtifica rtor, p	Be C	25. Was case referred to medical examiner?			26. P	ace of Death	(Check only one)	X No 1 □	Yes 2 U No			
7	hysic his ce I direc	인	1 ☐ Yes 2X No	lospital: 1 ☐ Inpatient 2			er: 4 🗌 Nurs	sing Home 5 Resid	dence 6 Other (S	oecify)			
٥	ling P	ate:	27. Manner of Death X☐ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Yea	28b. Time of injury	work	ζ?		now injury occurred				
Sion	death death ctor: y the	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be		at home, farm, st		Yes 2 N		Street and Number or	Rural Route Number			
Division of Vital Records, P.O. Box 687	al or A s after I Dire d in b		4 Homicide determined	building, etc. (Spe		,,,		City or Tou		ridia riolite ivarilosi,			
_	ospita hours unera ed fille	Medical		ician: To the best of my kr						stated. he cause(s) and manner stated.			
	the H hin 24 the F Tplete		only one) 3 Certifying Nurs	e Practioner: To the best of		death occurred at th	e time, date a		e cause(s) and manner	as stated.			
	// 6 Y		29b. Signature and title of certifler	1D		29c. Licens D 698			29d. Date signed (Mo				
	50		Sangertha L. N 30. Name and address of person who co		tem 22a) /Fires				7/29/20				
			Sangeeta Ranga		, , , , .	rest Gl	en Rd	. Silve:	r Spring	,MD 20910			
	Stat		31. Date filed (Month, Day, Year)	2. Registrar's Si		12.3							
	Registra	ir	AUG 04 2010	Cenura	13. 19 an	7							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

		1 - For State Registrar	State of IVI	aryianu /		tificate of L		ivientai ny	ygiene Reg. N	Z U I U	25875
Physicia		1 A W P B D W 1 A W 2 H A P P 1 S A D D D D D D D D D D D D D D D D D D									
Medi Exami		4a. Facility Name (if not institution, give	ve street and number)	OD TO A T			r Location of Death			c. County of Death	
Funeral	-		Sex 7. Age	SPITAL e (In yrs. last b		If Under 1 Year	FREDERIO	8. Date of B	irth	9. Birth	place (State or Foreign
Director		230-20-8205 Usual Residence of Decedent	1 🕅 M 2 □ F	83	Yrs.	Months Days	Hours Min.	SEPT.	21,	1926 VII	GINIA
tand show dat	tor	10a. State 10b. County		10c. City, To	wn or Loc	cation					10d. Inside City Limits
e Mary r 28a-1 notifie	Director	MD CHARLES 10e. Street and Number	S	NEWBU	JRG	105 75- 015					1 🕅 Yes 2 🗆 No
n with th Is 23a o	Funeral	12455 SHILOH CHU	RCH ROAD			10f. Zip Code 2066	4			Citizen of What Court TED STATE	
Ind 21215-0036 filed within 72 hours after death with the Maryland tal Hygiene. do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	11. Marital Status 1 ☐ Never Married 2 【 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 1 Yes 2 If Yes, Give Year or Dates.		5	Vas Decedent of H Yes, specify Cuba ☐ Yes 2 X No	an, Mexican, Puert	pecify Yes or No o Rican, etc.)) #* :	14. Race - Americ Black, White, Specify: BLA	etc.
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", o traumatic event, the Medical Exam	Completed	15. Decedent's (Specify only highest g Elementary/Seconday (0-12)		+)	(Give I life. D	lent's Usual Occup kind of work done o DNOT use retired) KDRIVER	during most of wor	rking		Kind of Business In	,
Iryland 2 ould be filed w the Mental Hyg marked othe imatic event,	To Be	17. Father's Name (First, Middle, Last, ERNEST HARRIS)				18. Mother's Nar SARAH	me (First, Middle HOWARD			-
y, Maryla nd 2 should be ealth and Men m 27 is marke ier traumatic		19a. Informant's Name/Relationship (IRENE E. HARRIS/V								or Town, State, Zip (G, MARYLA	
Baltimore, N permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to		20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec	cify)	ceme	tery, cren ERANS	sition (Name of natory or other plac CEMETERY	AUGUS	Date T 10, 201	ıb cı		I, MARYLAND
Ball permit Depar Impor any in		21. Signature of Funeral Service Liger	TON JOHNSON M	00583	22	Name and Address THORNTON	ss of Facility FUNERAL INGSTON	HOME, T	and an	N HEAD, M	D 20640
Proviciano		23a. Part 1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line		not ente		g, such as cardiac	or respiratory a	ırrest,		Approximate Interval Between Onset and Death
Medical Examiner	l.		Due to (or as a	consequence	e of):						
ped sit	Examiner	Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a	t Consequente	u utj.						
Certificate be executed certificate be executed and use as the burial-transit	Exa	that initiated events resulting in death) Last	C. Due to (or as a	consequence	e of):						
3760 ificate be g physici as the bu	Medical		d								
Box 68 death certifi he attending ed for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live Birth at Pregnant at 9 Unknown	2 🗌 Fetal dea		Ectopic pregnanc Other (specify)	Sy .			23d. Date of delive	ery Day Year
, P.O. ss that the igned by the be detach	by	Part II. Other significant conditions Aure Renau	contributing to death be		g in the u	nderlying cause giv	en in Part I.			use contribute to the	
VItal Records, ysician: The law requires is certificate has been sig	Completed		inotion	<u>e</u>				24a. Was			pably 4 Unknown
Hec The law arte has	Somp	FI I I G	1107100					auto	opsy ormed?	death?	psy findings available mpletion of cause of
tal	Be	25. Was case referred to medical examiner?	Hospital:				ace of Death (Che				
Physical chiral	은	1 Yes 2 No 27. Manner of Death	1 Inpatie	ent 2 ER/0	Outpatien . Time of	t 3 DOA Othe	4 L Nursing H			6 Other (Specify)
on o ath. r: After ne fune	icate	1 ☑ Natural 5 ☐ Pending 2 ☐ AccidentInvestigation	(Month, Day		injury	work		28d. Describe	now injui	ry occurred	
DIVISION OF tal or Attending Pt rs after death. al Director: After th ed in by the funeral	Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined			farm, stre	et, factory, office		28f. Location (City or To		nd Number or Rural e)	Route Number,
he Hospita in 24 hours he Funera	Medical	(Check 2 L Medical Exan	ysician: To the best of miner: On the basis of ex rse Practioner: To the basis	amination and	Vor investi	igation, in my opinio	on, death occurred	at the time, date	and place	e, and due to the car	use(s) and manner stated.
To t Voith		29b. Signature and title of certifier	.c. Sur	rive-		29c. License	0653			ate signed (Month, I	
		30. Name and address of person who	completed cause of de) (Type, P	rint) GYA	-N.C.	SURA		- Z - Z	0,0
24/ Sta	10	5 \$ 5 1 - 31. Date filed (Month, Day, Year)	Deale 32 Registra	CNW r's Signature	nul	ton 1	cocl	Deale	j	n.D. :	2075)
Registr		AUG 0 4 2	010 June	v B.	100	wes					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2010 Physician/ Month August <u>Virginia Armiger Hoover</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Annapolis Anne Arundel Arbor at Baywoods If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🛣 F 10/10/1916 Director 217-38-0762 93 Yrs. Usual Residence of Decedent 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at Director Maryland | Anne Arundel Lothian 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? by Funeral 6063 Pindell Road 20711 and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🛣 No 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: White If Yes, Give 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Anne Arundel County Elementary/Seconday (0-12) College (1-4 or 5+) Public Schools Teacher vears Be Page 1 and 2 should be filed in ment of Health and Mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Gertrude Hilson Daniel N. Armiger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Virginia A. Tucker/ Daughter 6063 Pindell Rd., Lothian, MD 20711 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Kalas Crematory 8/3/10 Edgewater, Maryland 21. Signature pitch haral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician/ C0/2/10 Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Examin physician and the burial-transit that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Por Pregnant at time of death ned by the 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by sign d be The law requires 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Records, 24a. Was an autopsy performed Yes 2 No Hospital or Attending Physician: 25. Was case referred to medica **Division of Vital** director, Be 26. Place of Death (Check only one) examiner? Hospital: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Exam 3 Certifying Nu Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of certifier

25876

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

Interval Between Onset and Death

1 🗆 Yes 2 🔀 No

Maryland

USA

Black, White, etc.

Month

1 Yes

Day

24b. Were autopsy findings available prior to completion of cause of death?

Year

10:30 AM

Registrar

Ahnapolis Rd # 228 Glenn Sole MS JavaKoli 12200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

		1	For State Registrar	State of Marylar	nd / Depa <i>Cei</i>	artment of F	lealth and N Death	lental Hy	giene Reg. No	2010	25877
			Decedent's Name (First, Middle,	,				2. Date of De Month	eath Da	v Year	3. Time of Death
	sicia edica		JOHN	ALFRED	HARLE	Y		JULY	26	2010	7:25 P M
	ımine		4a. Facility Name (If not institution,				r Location of Death			. County of Death	
**				E'S HOSPITAL 6. Sex 7. Age (In yrs.	last hirthday)	CHEVEI	LY If Under 24 Hrs.	8. Date of Bi	rth	RINCE GEO	ORGE'S pplace (State or Foreign
Fune Direc			5. Social Security Number 216-58-7889	1X M 2□ F 56	Yrs.	Months Days	Hours Min.	(Month, D	ay, Year)	Cot	untry) YLAND
D		ŀ	Usual Residence of Decedent							1 12111	
rylan			10a. State 10b. County	10c. Ci	ity, Town or Lo	cation					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
ne Ma 8a-fs		Director		GEORGE'S LA	NDOVER				10a Ci	tizen of What Co	
with th	3		10e. Street and Number 6406 SOUTHLAND	DRIVE		10f. Zip Code	785		USA		unity:
leath	9	Funeral	11. Marital Status	12. Was Decedent Ever in U	J.S. 13.	Was Decedent of H	Hispanic Origin? (Sr	ecify Yes or No		14. Race - Ame	
DalkImore, Iwaryiand 21213-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show	ramper	by Fur	1 ☐ Never Married 2 【X Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1		If Yes, specify Cub 1 □Yes 2 📉No	an, Mexican, Puerto Specify:	Rican, etc.)		Black, White	
15-UU36 72 hours aft "natural", or	Clical E	Completed	15. Decedent's (Specify only highest	s Education	(Give	dent's Usual Occup	during most of work	ing	16b. k	Kind of Business/I	industry
within ene.	Sa l	dmo	Elementary/Secondary (0-12) 12TH	College (1-4or 5+)		DO NOT use retire UTO MECHA				PRIVATE	7
filed Hygin	ent, II	Be	17. Father's Name (First, Middle, L	ast)	, A	OTO_IILOIM	18. Mother's Nam	e (First, Middle	e, Maider		
land	A CIC ev	10 B	THOMAS HENRY	HARLEY			MARY	MARIE	NEWM	IAN	
ary shot and h	anma anma		19a. Informant's Name/Relationshi	p (Type. Print)	19b. Maili	ng Address (Street	and Number or Ru	ral Route Numb	ber, City	or Town, State, Z	Zip Code)
C, IV	Je de			CKLEY - Sister			RIVE LAND				
ges 1 If ite	ا ا		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 D Romoval from State	cemetery, crei	osition (Name of matory or other pla	ce)	Date		ocation - City or	,
Saltimo bermit. Pages Department of mportant: If i	dini.		4 ☐ Donation 5 ☐ Other (Sp				ETERY $8/3$ ess of Facility \overline{J} .			NTON, MAI	
Depa Depa Impo	any		21. Signature of Funeral Service L	censee			OVER ROAD				
		7	23a. Part 1. Enter the disease, or o shock, or heart failure. List of	complications that caused the dea						IAKILAND	Approximate Interval Between
* Priysici	coll :	170	Immediate Cause (Final	only one cause on each line. METASTATIO							Onset and Death
/Medi	cal		disease or condition resulting in death)	Due to (or as a conse		ILLIOD IIL	TANGIO LI	LIMBHIO	, LLIA		
Examir	-		Sequentially list conditions.	b. RESPIRATOR		URE					
D ::	100	ji e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	quence of):						
execut and	al-tran	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a conse	quence of):						
icate be executed physician and	a DOLL	dical	Į.	ď							
tificat di phy	as III	w									
BOX atth cer attendir	e ne	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet		☐ Ectopic pregnan	су			23d. Date of del	•
ding Physician: The law requires that the death certificate has been signed by the attending factors of the control of the con	or paus	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown	death 5	Other (specify)				Month	Day Year
s that	e deta	by Pt	Part II. Other significant condition	ns contributing to death but not re	sulting in the u	inderlying cause gi	ven in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
law requires as been sign	g ping		CELLULITIS					1 🗆	Yes 2	Pr No 3 Pr	obably 4 Unknown
law reas be	Z SILC	Completed	ANEMIA					24a. Was		24b. Were au	topsy findings available completion of cause of
The cate h	hage	Com						perf 1 □ Yes	ormed?	death?	2 √ □No
VITAL sician; T certifical	actor.	Be	25. Was case referred to medical examiner?	Hospital:		Ott	26. Place of Dear			-	
Phys of the state	<u> </u>	<u>٩</u>	1 Yes 2 No 27. Manner of Death	1 Inpatient 2	ER/Outpatie	nt 3 L DOA	4 LI Nursing H	ome 5 Res		6 ☐ Other (Spec	cify)
Attending at death.		i jo	1 Natural 5 ☐ Pending 2 Accident investiga	(Month, Day, Year) ation	Injury	of 28c. Inju Wor M 1	rḱ?]Yes 2 □No			.,, 000000	
VIS rector	à l	Certification:	3 Suicide 6 Could no 4 Homicide determine			reet, factory, office		28f. Location City or To	(Street a	nd Number or Ru	ıral Route Number,
ital or ris after ral Die	200	5	- Indining	ballaling, etc. (Opec			_ 4	Only of To	rwii, Olai		
To the Hospital or Attending Physician: The law requires that the death certificate to the Fueral Director: After this certificate has been signed by the attending from the Funeral Director. After this certificate has been signed by the attending from the funeral director after the funeral director.	letery II	Medical		g Physician: To the best of my kn Examiner: On the basis of examin and manner stated.							
To th To th	E03	Ž	29b. Signature and title of certifier	Re		29c. Licens	se number		29d. Da	ate signed (Monti	h, Day, Year)
			Timele	Duenns		D2	1428			JULY 29,	2010
R.	5		30. Name and address of person v			,		A D 111		705	
V	Stat	e	31. Date filed (Month, Day, Year)	EN M.D. 3001 HOS 32. Registrar's Sign	SPITAL nature	DRIVE CH	EVERLY, M	AKYLANI) 2()785	
Reg	gistra		AUG 0 3 2010	32. Registrar's Sign	park						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 25878 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2010 Physician/ Erwin Carl Haberer, Jr. 8:41 July Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 8705 Rhode Island Avenue College Park Prince George's 8. Date of Birth (Month, Day, Y 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 🖾 M 2 🗆 F Months Hours 218-28-4143 79 **Director** Washington, DC Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Direct Maryland Prince George's College Park 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20740 8705 Rhode Island Avenue USA hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, rmed Forces?

Yes 2 \sum No Black, White, etc. þ 1 X Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. 1952–1960 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working filed within 72 al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) United States College (1-4 or 5+) Department of Agriculture Machinist other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H မ Maria Stoll Erwin Carl Haberer, Sr. permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terri E. Leonard / Cousin 1507 Ingalls Road, Glen Burnie, MD 21061 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Fort Lincoln Cemetery 8/2/2010 Brentwood, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Primary Pulmonary Hypertension disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. dequalities and the cause of th Due to fur as a consequence of Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 9 Unknown g | IInknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy Yes 2 X N 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 🔀 No 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural injury 5 Pending work? 2 🗆 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) Medical 29a. Certifier 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Definition in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 00070102 07-27-2010

Registrar
DHMH 17 Rev 7/2009

7+1

Ivan Ngang Zama,

AUG 0 3 2010

9200 Basil Court, Suite #200, Largo, MD 20774

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Clarence Hutt, Jr. 8246 M 2010 Sulu Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHIODUY Makal 9. Birthplace (State or Foreign Country) MD If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 1 🏿 M 2 🗆 F Months Hours (Month, Day, Year -10-192 215-14-3323 Min. Director 83 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Tes 2 No Wicomico Salisbury MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 29339 Naylor Mill Lodge 21801 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specialack 3 Wildowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working filed within 72 al Hygiene. life. DO NOT use retired) Blind Elementary/Seconday (0-12) College (1-4 or 5+) Industries 5 Seamstress permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Agnes Parsons Clarence Hutt, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Salisbury, MD 21801 29339 Naylor Mill Lodge, Beulah Hutt/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-6-2010 <u>Hill</u> LHebron, MD Spring Mem 21 Signature of Juneral Service Licensee Bennie Smith 917 W. Isabella St. Home Salisbury, MD 21801 Funeral Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ASCYD disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or finjury Due to (or as a consequence of) Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Innerial director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) Month Dav Year Pregnant at time of death 1 ∐ Yes ∠ ∟ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed Yes 2 death? 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: No No ၉ 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28c. Injury at Certificate: 28a. Date of injury 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending Division 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 🗌 No Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature p nd title of certifie 29c. License number 7/3/10 D63199 dress of person who completed cause of death (Item 23a) (Type, Print) SAlisbury Mal 100 E CARROLL ST. MD. State Registrar

DHMH 17 Rev 7/2009

Box 68760

P.O.

Records,

of Vital

10-05930 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Harry W. Henry, III State of Maryland / Department of Health and Mental Hygiene 2010 25880 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month **Medical Examiner** Harry Wesley Henry, Jr. III 1023 hrs August 7, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Atlantic General Hospital Worcester 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Director 214-90-9140 1 X M 2 F 45 Nov 26, 1964 Country) MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County PA Franklin Waynesboro 1 X Yes 2 No Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shu or other traumatic event, the Medical Examiner must be notified at once Director 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 8361 Stottlemyer Road 17268-9214 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? White, etc. African-Army 1 Never Married 2 X Married American If Yes, Give Year 3 Widowed 1 Yes 2 X No specify: 4 Divorced ğ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) l other than " Baltimore, MD 21215-0036 12 Self Employed Plumbing Company 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Lucille Blake Henry W. Henry, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8361 Stottlemyer Rd., Waynesboro, PA 17268-9214 Kathy A. Henry/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Important: injury or oth 8/14/2010 Mt. Wesley UMC Cem Snow Hill, MD Donation 5 Other Specify. 21. Signature of Funeral Service Licen 22. Name and Address of Facility Lewis N. Watson Funeral Home, PA 1618 West Rd., Salisbury, MD 21801

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical Electrocution Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and The law requires that the death certificate be executed Physician/Medical attending physician or use as the burial -XUNPENDED X AMENDED 23a, 27,28a-f, per ME g907 9/28/10 TT Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown detached Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>&</u> 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available has been autopsy prior to completion of cause of performe death? ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other Nursing Home 5 Residence 6 Other this 2 No 1 🗸 Yes 28d. Describe how injury occurred

Death

Year

Hospital or Attending Physician: Division of Vital After within 24 hours after death.

To the Funeral Director: the

28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification 1 Natural 1 Yes 2 X No subject was electrocuted Pending 9:30 am 8/7/2010 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Jown, State) 11909 Sinepuxent Rd Berlin, MD private dwelling determined 29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29h Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 8, 2010

State Registrar

Laron Locke MD.

31. Date filed (Month, Day, Year)

30. Name and address of person who commeted cause of death (Item 23a)

Assistant Medical Examiner

32. Kegistrar's Signature

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			for State Registrar	otate of Ivialyia		tificate of L			Reg. No. 2010	25881			
	Physicia	ın/	Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day Year	3. Time of Death			
,	Medic Examin	cal	Geneva Ann 4a. Facility Name (if not institution, give str	Hornsby eet and number)		4b. City. Town, or	Location of Death	Augus	t. 3, 2010 4c. County of De	03 = 47 _M			
-	LXdIIII		TENINSULA RAGIONAL		renter	54	usbucy			om I co			
	Funeral Director		5. Social Security Number 220−32−8965 6. Sex 1 □	M 2 F 7. Age (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt 08/31/		irthplace (State or Foreign ountry) CGINIA			
	show show	o.	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Lo	cation				10d. Inside City Limits			
	Maryli 28a-f otified	Director	Maryland Wicomico	E	lden					1 ☐ Yes 2 🔀 No			
	/ith the 23a or st be r	ralD	10e. Street and Number 14410 Dogwood Dr	rive		10f. Zip Code 21822			10g. Citizen of What C	Country?			
	death v	Funeral		Was Decedent Ever in U.s Armed Forces?	S. 13. V	Was Decedent of Hi f Yes, specify Cuba		ecify Yes or No-	14. Race - Am				
21215-0036	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	by	1 Never Married 2 Married 3 Midowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates.		Yes 2 X No		nican, etc.,	Black, Whi	ite, etc. white			
15-(72 hou n "nat Nedica	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give I	dent's Usual Occup kind of work done o O NOT use retired)	ation during most of worl	king	16b. Kind of Business	s Industry			
212	ed within Hygiene. other tha		Elementary/Seconday (0-12)	College (1-4 or 5+)	1	odial			poultry				
Maryland	should be filed n and Mental Hy r is marked oth raumatic event	To Be	17. Father's Name (First, Middle, Last) Leonard Griffith					ne (First, Middle, Shockle	Maiden Surname) ey				
	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type Debbie Rains/daugh						r, City or Town, State, Z nd, MD 2182				
Baltimore,	Page nent o ant: If ury or		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Wis	Place of Dispo Controco Park	sition (Name of	e) 8/6,	Date /2010	20c. Location - City of Salisbur	·			
Balt	permit. Pag Depar mer Impor ant any injury once,		21. Some of Fundal Serve Licens		22	Harreand Address 501 Snow	Fineral Hill Rd.	Home Pro	ofessional oury, MD 21	Associaiton 1804			
Lan	Physician/		Approximate Interval Between Consett and Death Conset and Death Conset										
29.00	Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):	ASUN				Sylans			
	ed nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a consequ	uence of):	CVA				Sylans			
_	ificate be executed g physician and as the burial-transit		that initiated events c. resulting in death) Last	Due to (or as a consequ	uence of):								
8760	ficate g phys as the	dedical	d.				-		1				
Вох 68	ath cert attendir for use	Physician/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	s. If yes, outcome of preg <i>n</i> a 1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of o 9 ☐ Unknown	al death 3	Ectopic pregnanc Other (specify)	у		23d. Date of de Month	elivery Day Year			
P.O.	requires that the de been signed by the should be detached		Part II. Other significant conditions contr	ibuting to death but not res	sulting in the u	nderlying cause giv	ren in Part I.	23e. Did to	bacco use contribute t	to the cause of death?			
ds, l	quires t en sign tuld be	d pa						1 🗆 🗅	Yes 2⊠No 3□I	Probably 4 🗆 Unknown			
of Vital Records,	The law recate has be page 2 sho	Completed by						24a. Was a autop perfor	psy prior to death?	utopsy findings available completion of cause of			
tal	ysician: The is certificate director, pag	Be	25. Was case referred to medical examiner?	spital:			ace of Death (Chec		Z Z III				
Ϋ́	dir	e: 10	1 Yes 2 No 27. Manner of Death	1 Inpatient 2 28a. Date of injury	ER/Outpatien 28b. Time of	ot 3 DOA Other	4 L∃ Nursing H		lence 6 Other (Spe	cify)			
ion o	Attending Physician: or death. ector: After this certific by the funeral director,	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Day, Year)	i <i>n</i> jury	M 1 🗆							
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral		4 ☐ Homicide determi <i>n</i> ed	28e. Place of Injury - At ho building, etc. (Specify	()			City or Tow					
	e Hosp 124 ho e Fune eleted f	Medical	(Check 2 🗀 Medical Examiner	an: To the best of my knowl : On the basis of examination Practioner: To the best of my	n and/or invest	igation, in my opinio	n, death occurred a	it the time, date ai	nd place, and due to the	cause(s) and manner stated.			
_	To the within 2 To the comple	_	29b. Signature and title of certifier	,	,	29c. License			29d. Date signed (Mon				
	7		mha Na			(14	005/359		August.	3rd 2010			
	Sy		30. Name and address of perso <i>n</i> who con	pleted cause of death (Item TどろAN 1415			ST SA	LISBURY	M) 218	04			
	Stat Registra		31. Date filed (Month, Day, Year) AUG 0 4 20	32. Registrar's Signat	ture	IVISION							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien® ೧ I ೧

			For State Registrar	State	of Marylan	d / Depa <i>Cei</i>	artment of H	Health and Death		gien e ()	10	25882
			Decedent's Name (First, Middle,	Last)					2. Date of Dea	ath		3. Time of Death
	Physicia		Dorothy G	Tngko	en				July 31	. 2010	Year	0210 M
	/Medio Examin		4a. Facility Name (If not institution,				4b. City, Town, o	r Location of De			ty of Death	
207	LAdiiiii		Carroll Hospic	re Dove	House		Westm	inster		Ca	arroll	1
Т	Funeral			. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 I	Hrs. 8. Date of Birt	h v. Year)	9. Birth	place (State or Foreign
	Director		292-20-8553	1 ☐ M 2 💢 F	86	Yrs.	Withins Days	Tiodis	Mar 19	, 1924	Ohio	
	pu >		Usual Residence of Decedent 10a. State 10b. County		100 0	v, Town or Lo	ootion					10d. Inside City Limits
	aryla shov	'n			100. Cit	•					Ι.	1 X Yes 2 □ No
	he M	Director	MD Cari	roll		Westr	ninster 10f. Zip Code			10g. Citizen of	f M/h ot Coul	
	a or		_					157				nd y :
	eath is 23	era	36 Fitzhugh Ave		cedent Ever in U.	S 13 1		.157	/Specify Ves or No.	USZ	ace - Americ	can Indian
	item in	Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Marrie	Armed F		0. 10.	If Yes, specify Cub	an, Mexican, Pu	? (Specify Yes or No- uerto Rican, etc.)	BI	ack, White,	
336	Irs af	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, G	aive		1∐Yes 2⊠No	Specify:		Spec	ify: W	nite
ŏ	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, tha Micdeal Examinar must be metified at	ted	15. Decedent's	Education			dent's Usual Occup			16b. Kind of I		
215	7 nin 7. Se n' n	Completed	(Specify only highest Elementary/Secondary (0-12)		(1-4or 5+)	(Give life. I	kind of work done DO NOT use retire	during most of d)	working			
21:	d with giene	E O	12	Conege	(1-401 0+)	Organ	nist/Pian	ist		Churc	ch	
g	al Hy othe vent,	Be C	17. Father's Name (First, Middle, La	ist)		_		18. Mother's I	Name (First, Middle,	Maiden Surna	ıme)	
<u> </u>	uld by Menta rrked tic e	2	H. Lyell Coler:	ider				Pauli	ne Brooks			
Maryland 21215-0036	s.1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Maddell Examination in all the notified at		19a. Informant's Name/Relationship	o (Type. Print)		19b. Mailir	ng Address (Street	and Number of	r Rural Route Numbe	er, City or Tow	n, State, Zij	p Code)
	1 and 2 Health tem 27 i		Kenneth M. Insk	ер Н	lusband	36 F:	itzhugh A	we.	Westminst	er, MD	2115	57
ore	of He		20a. Method of Disposition 1☑ Burial 2 ☐ Cremation 3	□ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	20b. F	Place of Dispo cemetery, crer	sition (Name of natory or other pla	ce)	Date	20c. Location	ı - City or To	own, State
altimore,	Pages. ment of ant: If its ury or o		4 Donation 5 Other (Spe			adow Bi	canch Cem	eterv	8/4/10	Westmin	nster	, Maryland
a	permit. Pages 1 and Department of Heal Important: If item 2 any Injury or other once.		21. Signature of Funeral Service Li	censee 0		22	2. Name and Addre	ess of FacilitPr	ritts Fune	ral Hor	me & (Chapel, PA
m —	9 9 = 2 9		John K.	HYE	7	41	l2 Washin	gton_Ro	l. Westmi	nster,		21157
п			23a. Part 1 Enter the disease, or construction shock, or heart failure. List or	omplications that	caused the deat	h. Do not ent	er the mode of dyi	ng, such as car	diac or respiratory a	rrest,		Approximate Interval Between
de la	Physician		Immediate Cause (Final disease or condition			TIC (DROPHA	RYNGE	AL CAR	CINOM	A	Onset and Death
	/Medical		resulting in death)		o (or as a conseq							2 16
	Examiner		Semedially list contlines	b M	YASTHE	ENIA	GRA	TVIS				2 months
	P #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	o (or as a conseq	uence of):						
	ecute and trans	am	that initiated events resulting in death) Last	с								
50,	cian a		resulting in doutily Edist	Due to	o (or as a conseq	uence orj:						
8760,	ficate be executed physician and s the burial-transit	dical		d								
9 ×	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE:	23c If yes o	utcome of pregna	ancy						
. Box	atten for us	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	e birth 2 Feta	I death 3[☐ Ectopic pregnand ☐ Other <i>(specify)</i> _	су		- 1	Date of deliv Month	very Day Year
o.	he d	ysic	1 □ Yes 2 ☑ No 9 □ Unknown	9 🗆 Unk		leatii 5L	_Other (specify) _					
P.0	uires that the de signed by the a d be detached f	Ph	Part II. Other significant condition	s contributing to	death but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use co	ntribute to	the cause of death?
Records,	sign d be	d by	Depression						1 🗆 1	res 2 No	3 ☐ Pro	bably 4 🗍 Unknown
Ö	w requir been s should	etec							24a. Was	00 041	h Woro out	opsy findings available
Rec	has ge 2 s	Completed			· ·		-		— autor		prior to co death?	ompletion of cause of
_	ician: The l certificate ha ector, page								1 ☐ Yes	2 🗹 No	1 ☐ Yes	2 🗆 No
Vital	sicial certi recto	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	71	FD 10	Oth	oer.	Death (Check only o	/	<i></i>	in Hospice
ō	Phys r this ral di	٦.	27. Manner of Death			ER/Outpatier 28b. Time of	IL 3 L DOA	4 🗆 Nursir	ng Home 5 Resident			ity) ((OS))(CE
on	ding F h. After funera	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investiga		e of Injury onth, Day, Year)	Injury	Wor	rḱ?]Yes 2. □No		,,		
Division of	Attency death	Certification: To	3 ☐ Suicide 6 ☐ Could no	t be 28e. Plac	ce of Injury - At he	L_ pme, farm, str	eet, factory, office		28f. Location (Street and Nur	nber or Rui	ral Route Number,
	after Dire d in b	erti	4 Homicide	buile	ding, etc. (Specii	(y)			City or Tov	vn, State)		
	spital or nours afte neral Dir / filled in								lace, and due to the			
	To the Hospital or Attending Physician: whin's 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p	Medical	(Check only 2 Medical E. one)		basis of examina inner stated.	ation and/or in	vestigation, in my	opinion, death o	occurred at the time,	date and place	e, and due t	to the cause(s)
	To the vithing of the complex of the	Ž	29b. Signature and title of certifier	68.			29c. Licens			29d. Date sign	1	, Day, Year)
	ار		year				Do	06155	8	8/	2/10	
,	m45		30. Name and address of person w	no completed car	use of death (Iter	n 23a) (Type,	Print)			,		11-0
IJ	75W		FALLUNI PARIK				, STE 30	05, WE	ESTMINITA	EK, M.	DL	1157
	Sta Registr		31. Date filed (Month, Day, Year)		Registrar's Signa	ture	a Kal					
		91	11111111111	/11 11 1 / /d	THE REPORT OF THE PARTY OF THE		UC / GAGA					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 25883 Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 07/30/2010 MARY LOUISE JOHNSON 8:30 A Medical 4a, Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 14761 Sugarland Road Montgomery Poolesville Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Funeral 7. Age (In yrs. last birthday) 1 M 2 X F Hours Min. 12/24/192 Director 218-16-0080 88 Usual Residence of Deceden ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director 1 X Yes 2 □ No MD Poolesville Montgomery 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14761 Sugarland Road 20837 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 0. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Black "natural", 3X Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 27 is marked other than traumatic event, the Me Montgomery County Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Housekeeping Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Howard Foreman Geneva Murray 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 shou Department of Health and Important: If item 27 is m any injury or other traum: 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nettie LaMaster - daughter 4761 Sugarland Road, Poolesville, MD 20837 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Paul Church Cem. 1 X Burial 2 Cremation 3 Removal from 8/7/10 Poolesville, MD 4 Dong n 5 D Other (Specify) 22. Name and Address of Facility Snowden Funeral Home J Funeral Service License 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician, 2 months disease or condition Medical resulting in death) thue Pulmonary Disease Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and To the Hospital or Attending Physician: The law requires that the death certificate be exect Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Month Day Year Unknown 9 🔲 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this certificate 1 Yes 2 No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 Hospital Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Dear 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 - Homicide determined City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only on Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatu 29c. License number address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar Jonathan Plotsky
31. Date filed (Month, Day, Year)

Registrar's Signature

15225 Shady Grove Road, #102, Rockville, MD 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 0220AM Johnson 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death SA 2136404 HICOMCO TENIASUUD KAGIONAL If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth (Month, Day, Year) March 14,1929 1 ፟፟፟፟ M 2 ☐ F Months Days Director Maryland 213-22-7708 81 Usual Residence of Decedent or 28a-f show 10a. State 10c. City, Town or Location Examiner must be notified at Director 1 ☐ Yes 2 X No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 110 Lakeview Drive 21804 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Page 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examin onee. Black, White, etc. 2 1 Never Married 2 X Married 1 XYes 2 No If Yes, Give 1948 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced -1952Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Carpenter Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Johnson Reta Livingston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Sue Johnson- Wife</u> 110 Lakeview Dr. Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗆 Burial 2 🗷 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva 8/2/2010 Delmar, Delaware 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bounds Funeral Home Salisbury, MD 21804 <u>7</u>05 E Main St. 23a. Part 1. Enter the disease, or computations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ schemic disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami The law requires that the death certificate be executed for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ___ in the past 12 months? Month Year Day Yes 2 ☐ No signed by the a ld be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? this certificate has performed 2 🗌 No Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: မ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred nin 24 hours after death.

the Funeral Director: After appleted filled in by the funeral public for the funeral broad and a fulled in by the funeral broad and a fulled in by the funeral fulled in by the funeral fulled in by the funeral fulled in by the funeral fulled in by the funeral fulled in by the funeral fulled in by the funeral fulled in by the funeral fulled in by the funeral fulled in by the funeral fulled in by the funeral fulled in by the funeral fulled in by the funeral fulled in by the funeral fulled in by the funeral fulled in by the funeral fulled in by the funeral fulled in by the funeral fulled in by the funeral fulled in by the fulled in by the funeral fulled in by the fulled in by the funeral fulled in by the funeral fulled in by the funeral fulled in by the funeral fulled in by the funeral fulled in by the funeral fulled in by the funeral fulled in by the funeral fulled in by the funeral fulled in by the funeral fulled in by the funeral fulled in by the funeral fulled in by the funeral fulled in by the fulled in by the fulled in by the funeral fulled in by the funeral fulled in by the funeral fulled in by the funeral fulled in by the funeral fulled in by the funeral fulled in by the fulled in (Month, Day, Year) 1 Natural 5 Pendina 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of certifier H6 1327

Registrar

Box 68760

Records,

Division of Vital

100 E. Cappour ST park

ss of person who completed cause of death (Item 23a) (Type, Print)

AUG 0 3

32. Registrar's Signature

Amend Item 1 per Phy. 08/02/10 Carroll Co., will

State of Maryland / Department of Health and Mental Hygiene

1- State Amend Item 25 per me, g907,09/01/2010dhb

Reg. N2 0 0 2, Date of Death 1. Decedent's Name (First, Middle, Last) DANIELLE KATHLEEN KNELL Month **Physician** Ninell 00:02 M Dame Ho July -8 2010 Kathleen /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Yrs. 215-33-7741 22 3, 1988 Maryland Mar Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County items 23a or 28a-f show 1 Yes 2 No Director Examiner must be notified MD Carroll Finksburg 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 1717 Yorkland Rd. USA 21048 Funeral Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 XNever Married 2 Married Yes XXNo ō Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 Yes 2 No Specify: Specify þ 3 Widowed 4 Divorced White "natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) and Mental Hygiene.

Is marked other than Florist Giant Food 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Deborah L. Holland Robert M. Knell ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health tem 27 1507 Ridge Rd. Westminster, MD 21157 Father Robert M. Knell Department of Healt Important: If item 2 any Injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation Ind 7/29/2010 | Hampstead, Maryland 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA 21. Signature of Funeral Service Lices 412 Washington Rd. Westminster, MD 21157 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1 Immediate Cause (Final **Physician** Due to (or as a constituence of): hemorrhage disease or condition resulting in death) /Medical **Examiner** embolus ulmonary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) CERTIFICATION APPROVED BY MEDICAL EXAMINER To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy Month Day in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 2 No 1 Yes 1 TYes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 Nes 2 No 2 Accident Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 7-28-2010 RES DOO WJL 5 30. Name and address of person who completed cause of death (item 23a) (Type, Print) Anthony 600 North Wolfe St. Baltimore, MD, 21287 31. Date filed (Month, Day, Year) 32. Registar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 25886 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day August 9, 2010 Medical Examiner 1635 hrs KEVIN SETH KIRBY 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 4020 Main Street Trappe Talbot 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY **Funeral** 9. Birthplace (State or Months Davs Hours oreian Director 219-78-7072 1 X M 2 F 50 1/21/1960 Country) MARYLAND Yrs Usual Residence of Decedent any 10a State 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 X Yes 2 No TALBOT TRAPPE . Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene, and the first fittem 27 is marked other than "natural", or items 23a or 28s-f sho or other tranmatic event, the Medical Examiner must be potified at once Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4020 MAIN STREET 21673 USA Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. White, etc. 1 Never Married 2 Married 2 X No Yes f Yes, Give Year or Dates: 4 X Divorced 1 Yes 2 X No specify: WHITE Specify ⋧ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 12 SPRAY TECHNICIAN LANDSCAPING 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) WILLIAM SETH KIRBY BARBARA POPE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KIM ANDERSON, SISTER 27525 CHORAS POINT ROAD, TRAPPE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State CHESAPEAKE CREMATION 8/14/2010 STEVENSVILLE, MD 4 Donation 5 Other Specify. 21. Signature of Funeral Service Licensee 22. Name and Address of Facilit FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 200 SOUTH HARRISON STREET, EASTON, MD 210 MERCEROL K JOHN 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear **Physician** failure. List only one cause on each line Between Onset and /Medical Death Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed and Physician/Medical 23a,pt.II, 27 per me g906 8-25-10 vt X UNPENDED AMENDED attending physician for use as the burial Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Fetal death Month Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? 호 1 Yes 2 No 3 Probably 4 Unknown Chronic Alcohol Use Completed After this certificate has been uneral director, page 2 should 24a. Was an 24b. Were autopsy findings available performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) Other₄ Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: Scene 1 V Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Director: 5 Pending 1 Yes 2 No Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 6 Could not be Suicide determined To the Funeral Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated nature and 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 10, 2010 Well atter 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Victor Weedn MD JD 111 Penn Street, Baltimore, MD 21201

Registrar

31. Date filed (Month, Day, Year) AUG

32. Registrar's Signature

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 25887 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2010 la 985 August 9:05 A^{M} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Heritage Harbour Health and Rehab Annapolis Anne Arundel Social Security Number 7. Age (In yrs. last birthday) 90 vrs If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 167-12-9629 1 M 2000 Days Min May 24 ₹920 Pennsylvania Director Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits notified at Director Maryland Anné Arundel Annapolis 28a-f 1 Yes 2 No ō 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r 21403 Funeral 1101 Lake Heron Drive, Apt. TD items 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Yes 2 No
If Yes, Give
Year or Dates. ò þ 1 Never Married 2 Married Maryland 21215-0036 White 1 Yes 2 XXNo Specify: Specify "natural" Completed **ॐ**Widowed 4 □ Divorced the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Secretary State Government 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

Mary T. (unknown) and 2 should be fill Health and Mental tem 27 is marked ည Herbert R. Sulzer 19a. Informant's Name/Relationship (Type, Print)
P. Honora Karslo/daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1101 Lake Heron Drive, Apt. TD Annapolis, MD 21403 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State **j** <u>∓</u> 1 XX Burial 2 Cremation 3 Removal from State ō Department of Important: If any injury or once. aurel Hill Cemetery 8/6/2010 Philadelphia, PA 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition Interval Between Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner 1-1 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence on Exami > P burial-transit and Due to (or as a consequence of) resulting in death) Last physician s the burial A Physician/Medical Box 68760 attending p IF FEMALE: signed by the attendin 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 month Day Year Pregnant at time of death 9 Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 2 Be 25. Was case referred to predical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending 24 hours a 'er decth. Funeral Director: Af 2 Accident
3 Suicide
4 Homicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner To the Sest of my knowledge, death consisted at the time, date and place, and dise to the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) hysician 08-05-590

Registrar DHMH 17 Rev 7/2009

State

Division of Vital

vater colony Drive

Amabolis Mi)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MAHBOOB

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 25888 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July **Physician** 2010 Esther Katsef 27 21:49 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Spa Creek Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 217-14-5981 1 □ M 2 🔽 F 97 Director 3/8/1913 Washington DC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

nt: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County injury or other traumatic event, the Medical Examinar must be notified at Director 1 ☐ Yes 2 No MD Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2703 Coriander Pl. 21037 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 □ Yes 2 ▼No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2√√No Specify: White 2 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home maker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Benjamin Ginsberg Sophie Sopher 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Stan Katsef (Son) 2703 Coriander Pl. Edgewater, MD 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XXurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 7/29/2010 Kneseth Israel Cem. Annapolis, MD 22. Name and Address of Facility Hardesty Funeral Home 21. Signature of Funeral Service Consee J. 12 Ridgely Ave. Annapolis, MD 21401 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final evelovovascular disease Physician YEAV'S disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of, or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Year Month 5 Other (specify) s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 2**)** No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After Natural 2 Accident ospitar ...
4 hours after dear.
-ral Director: Aftr 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital within 24 hours a 29a. Certifier 1 Secrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bestgate Rd. Annapolis. 900 ONICK 31. Date filed (Month, Day, Year) 32. Rehistrar's Signature State AUG 03 2010

DHMH 17 Rev 1/2001

Registrar

P.O. Box 68760.

State of Maryland / Department of Health and Mental Hygiens 25889 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 26, 2010 1:00P Jannie L. Kev July /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10201 Welshire Drive Upper Marlboro Prince Georges If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 💢 F 577-20-8282 Director 92 Jan. 16,1918 Mississippi Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heathh and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 10a State Director 1 ☐ Yes 2 No MD Prince Georges Upper Marlboro 10g. Citizen of What Country? 10e. Street and Number 10201 Welshire Drive 20772 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2√ No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: þ Black 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Personnel</u> Administrator Federal Government 7 is marked other traumatic event, if 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Reatha Lofton ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and:
Department of Health
Important: If item 27
any injury or other tr
once. Daughter 10201 Welshire Dr, Upper Marlboro, MD 20772 Ericka B. Key 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 7/29/2010 Riverdale, MD Riverdale PK Crem. 4 ☐ Donation 5 ☐ Other (Specify) TERRENCE L. JOHNSON FUNERAL SERVICE, 4433 WHITE PLAINS LN, WHITE PLAINS, MD 21. Signature of Funeral Serv P.A. Trops M01284 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ARDIA disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. physician Physician/Medical the attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Ye ar 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) ed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signe should be ģ 3 Probably 4 Unknown 1 □ Yes 211 NO Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has b autopsy performed? 1 Yes 2 No funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1∐ Yes 2 Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Unatural 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

The funeral Director: A setely filled in by the f death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OXON HILLRY, OXON State Registrar

Type of Fine in Black indensi	C IIIK. Ellouic All oopics Ale El	700000	
Ctata of Maniford / Danastman	nt of Health and Mental Hygie 2e0	111 258411	
State of Maryland / Departmen	il oi nealli and Mental nygleneo	10 20000	

		•	_ FUI	Certificate of Death	Reg. No.	,10 20000
	Dhusisi		Decedent's Name (First, Middle, Last)	2. Date o Month	Dav	3. Time of Death
	Physici /Medic		Clarence A. Lintz Sr.	Aug		010 7:45 A M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		County of Death
			20309 Gore Mill Road 5. Social Security Number 6. Sex 7. Age (In yrs. last birth)	Freeland day) If Under 1 Year If Under 24 Hrs. 8, Date of		Baltimore
	Funeral Director		219-34-0686	s. Months Days Hours Min. (Months s. May	Birth Day, Year) 3, 19	9. Birthplace (State or Foreign Country) MD
pue	M II		10a. State 10b. County 10c. City, Town of	or Location		10d. Inside City Limits
N 2	fied .	ţō	MD Baltimore	Freeland		1 ☐ Yes 21② No
h the	h the	irec	10e. Street and Number	10f. Zip Code	10g. Citize	en of What Country?
3	23e c	ai D	20309 Gore Mill Road	21053	U	J.S.A.
de s	tems	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1959	 Was Decedent of Hispanic Origin? (Specify Yes o If Yes, specify Cuban, Mexican, Puerto Rican, etc. 	No- 14	 Race - American Indian, Black, White, etc.
21215-0036 d within 72 hours after death with the Maryland	to the than and Mental Hygiene. If item 27 is marked other than "natural", or items 23e or 28e-f show or other traumetic avant, It a Medical Examination to the traumetic avant.	by	1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 2 □ Yes 2 □ No 1939 □ If Yes, Give Year or Dates: 1962	1 ☐ Yes 2 No Specify:	s	Specify: White
3 5	natu	ete	(Specify only highest grade completed) (9	ecedent's Usual Occupation Give kind of work done during most of working ife. DO NOT use retired)	16b. Kind	d of Business/Industry
121	than	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Manager	Auto	omotive
N E	othar vant,	e Co	17. Falher's Name (First, Middle, Last)	18. Mother's Name (First, Mic		
Maryland	kad c	OB	Clarence G. Lintz	Helen N. K	rebs	
aryla	and N s mai	_	19a. Informant's Name/Relationship (Type, Print) 19b. M	Mailing Address (Street and Number or Rural Route No	ımber, City or	Town, State, Zip Code)
	aalth n 27 i			09 Gore Mill Rd., Fr		
ore	of He of Itan or oth			Disposition (Name of Date of Organization Office Land)	20c. Loca	ation - City or Town, State
ii m	tent:		`4 □Donation 5 □ Other (Specify)	rvice 2010		ck, PA
Baltimore,	Department of himportent: If its any injury or of once.		21. Signature of Feneral Pervice Licensee	22. Name and Address of Facility J, J. Hai		
	10240		23a. Part1. Enter the disease, or complications that caused the death. Do no	24 N. Second St., Ne		Approximate
	hysician /Medical		shock, or heart failure. List only one cause on each line.		y a.r.o.,	Interval Between Onset and Death
			disease or condition resulting in death) a	increater concer		3 MANHO
E	xaminer					
		ner	Sequentially list conditions, if any, leading to immediate cause. Emer Underlying):		
68760, de	incate by consequently physician and as the burial-transit	Examine	Cause (Disease or injury that initiated events c.			
50,7	cian a		resulting in death) Last Due to (or as a consequence of	ı:		
68760, d	physi	edicai	d			
		100	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	_	23	3d. Date of delivery
Box	a attendin d for use	iciar	in the past 12 months? 1 Ves 2 Ven 4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	_	Month Day Year
P.O.	ed by the atte	Physician/	9 Unknown			_ 1
S, a	igned be de	ру Р	Part II. Other significant conditions contributing to death but not resulting in t	,,,	_	e contribute to the cause of death?
Record	been si		Hyperlipiaumia		∏Yes 2∐	No 3 Probably 4 Unknown
\$ & &	S S S	Completed	Alcoholism in remission		lutopsy	24b. Were autopsy findings available prior to completion of cause of
	ate pag	So	Perugheral arterial insu	Hickory 10 Y	erformed es 2 No	death? 1 🗆 Yes 2 🗆 No
of Vital	is certificate director, pag	Be	25. Was case referr to medical examiner? Hospital:	26. Place of Death (Check of Death (Check of Death)	/	
O A	this ral di	. To	1 ☐ Yes 2 ☑ No ☐ No ☐ Inpatient 2 ☐ ER/Outp 27. Mann of Death	ation of port	esidence 6	
O	th. After thi funeral	tion	1 Natural 5 Pending (Month, Day Year) Inj 2 Accident investigation			
Division Lor Attanding	after deat Diractor: in by the	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm	n, street, factory, office 28f. Locati	on (Street and	Number or Rural Route Number,
	s afte	Sert	4 Homicide determined building, etc. (Specify)	City of	Town, State)	
Hospit	within 24 hours after deat To the Funeral Director: completely filled in by the	edicai (29a. Certifier (Check only one) 1 ☑ Certifying Physician: To the best of my knowledge, 2 ☐ Medical Examiner: On the basis of examination and/ and manner stated.	death occurred at the time, date and place, and due to or investigation, in my opinion, death occurred at the ti	the cause(s) a me, date and p	nd manner as stated. place, and due to the cause(s)
ţ,	o the	Me	29b. Signature and title of certifier	29c. License number	29d. Date	signed (Month, Day, Year)
) [> - 0		> Elellus	D22557 ypa, Print) 4 Mt Carmel Rd	8	1912010
	maxI		30. Name and address of person who completed cause of death (Item 23a) (T	ypa, Print)	0 4	1. 1. 1020
	20		Elizabeth Schlenoff MD, 21	4 Mt Carmel Rd	rark:	m Ma 2160
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	_		
	Registr		AUG 182010 Seme & fores			
DHMI	H 17 Rev 1/2	001				

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25891 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 10° 2010° 2 Jack Thomas Linton 5:15pm м Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Northampton Manor Nursing Center Frederick Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Sep 20, Year 927 1 X M 2 🗆 F Days Hours Min. 216-22-9486 Mary land 82 **Director** Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ms 23a or 28a-f sho must be notified at 10d. Inside City Limits Director Maryland Frederick Frederick 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 814 Trail Avenue 21701 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No World

If Yes, Give Black, White, etc or, þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed Specify: White "natural" 3 Divorced Year or Dates. War II 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Agent Allstate Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Russell Herbert Linton Edith Marie Brandenburg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Mrs. Betty Mae Linton, Wife 814 Trail Avenue, Frederick, Maryland 21701 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Mt Olivet Cemeterv Aug 16, 2010 Frederick, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Reeneyd & Bastord P.A. Funeral Home eell M00706106 E Church St, Frederick, Maryland 21701 23a. Part 1. Enter the disea e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Kneum on itis Immediate Cause (Final mration Physician/ disease or condition resulting in death) Medical Due to (or # a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of by Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year • Hospital or Attending Physician; The law requires that the t 24 hours after death.
• Funeral Director, After this certificate has been sinned but the total or the control of Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 🛛 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 N death? 2 No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ✔ No Other: 9 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by th 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State)

State Registrar

Medical

29b. Signature and title of certifie

(Month, Day, Year) 182010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P.O.

Division of Vital Records,

DHMH 17 Rev 7/2009

Saeed A. Zaidi, M.D., 801 Tollhouse Avenue #E1, Frederick MD 21701-6111

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month. Dav. Year)

8-11-2010

29c. License number

D43091

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Llewellyn Beverly Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death WMHS-RMC Cumberland Allegany If Under 1 Year | If Under 24 Hrs. Months | Davs | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Country) MD 1 □ M 2 □ 🕏 Mar 3. Year 933 217-28-9686 Director Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Allegany Cumberland MD 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21502 817 Manns Terrace USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Specify: 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles E. "Buck" Jones Beulah P. (Broadwater) Jones 19a. Informant's Name/Relationship (Type, Print)
Nancy Llewellyn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code).
817 Manns Terrace Cumberland MD 21502 daughter 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State Sunset Memorial Park 8/11/201 MD Cumberland 4 ☐ Denation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and dame of Puliveral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter th. disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shot., or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Se Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** emia Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Lena physician and the burial-transit that initiated events Due to (or as a consequence of resulting in death) Last Physician/Medical Box 68760 attending phase as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 Yes 2 No Pregnant at time of death Unknown is been signed by the should be detached Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by METHLUN resus tent staph aurces 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Deabetus Millelles 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has this certificate 1 ☐ Yes 2 ☐ No ∐Yes 2 🛣 No Hospital or Attending Physician: **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 No Hospital: Other: ည 1 Tyes 1 Npatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work? within 24 hours after death.

To the Funeral Director; Af
completed filled in by the fu 2 🗆 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

ABOUL HANAN CHE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0066101

12-500 Willowbrook Rd cumberland mo 2152

Please	Type or Prin				-				
For State Registrar	State of Ma			of Health and of Death	Mental Hygie	ene 1. N2 0 1 0	25893		
1. Decedent's Name (First, Middle, La	111				Date of Death Month	Day Year	3. Time of Death		
0010100	Klear				August	9 2010	9:24 PM		
4a. Facility Name (If not Institution, giv				wn, or Location of Dea	ath	4c. County of Death			
Western Maryland 5. Social Security Number 6.8		center e (In yrs. last birthda		e rstown Year If Under 24 Hr	S. 8. Date of Birth	Washin	place (State or Foreign		
·	1 □ M 2 X F	73 Yrs.	Months E	(ear) Cou , 1937 Mar	intry)				
10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits		
MD N/A		Baltimo	re				1. Yes 2 □ No		
10e. Street and Number 1102 Druid Hill			10f. Zip Co	nde .201	100	g. Citizen of What Cou	•		
11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S. 13	3. Was Deceder	t of Hispanic Origin? (Cuban, Mexican, Pue	Specify Yes or No-	14. Race - Ameri Black, White			
1 Never Married 2 Married	1 Yes 2 X If Yes, Give Year or Dates:	No	1 □ Yes 2 X		0	ite			
3 ☐ Widowed 4 💢 Divorced 15. Decedent's E		16a. Dec	cedent's Usual C	Occupation	16	6b. Kind of Business/li			
(Specify only highest gr. Elementary/Secondary (0-12)	College (1-4or 5	(Gi	ve kind of work of DO NOT use i	done during most of w retired)	orking	Domestic	· · · · · · · · · · · · · · · · · · ·		
17. Father's Name (First, Middle, Last	r)	11011		18. Mother's N	ame (First, Middle, Ma				
Russell Schroyer	,			Moze11	. Denise Li	.1v			
19a. Informant's Name/Relationship		19b. Ma	iling Address (S		Rural Route Number, (ip Code)		
Cindy L. King/Da	ughter	7868	Fairp1	ay Rd., Fa	irplay, MI	21733			
20a. Method of Disposition 1 ☐ Burial 2 【A Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	fy)	Smithsbu	rematory or othe irg Cren	natory 8/1	1/2010	Oc. Location - City or T Smithsburg	, MD		
21. Signature of Funeral Service Lice 5. Mark 5	nsee .				Rest Haven Ave., Hage		-		
23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	ne.		of dying, such as cardi		it,	Approximate Interval Between Onset and Death YEAR S			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of the condition of the									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ऒ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3 □Ectopic preg 5 □ Other (spec			23d. Date of deliver Month	very Day Year		
Part II. Other significant conditions PNEUMONIA	contributing to death be	ut not resulting in the	underlying caus	se given in Part I.	23e. Did toba	cco use contribute to			
					24a. Was an autopsy perform	prior to c ed? death?	topsy findings available ompletion of cause of		
25. Was case referred to medical				26. Place of D	eath (Check only one)				
examiner? 1 ☐ Yes 2≰No	Hospital: 1 ☐ Inpatie	nt 2 ☐ ER/Outpat	ient 3□ DOA	Other: 4X Nursing	Home 5 ☐ Residen	ce 6 Other (Spec	rify)		
27. Manner of Death 11★Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Inju (Month, Day	ry 28b. Time (Year) Injun	of 28c	. Injury at Work? 1 ☐ Yes 2 ☐ No		28d. Describe how injury occurred			
3 Suicide 6 Could not be 4 Homicide determined		ury - At home, farm, c. (Specify)	street, factory, c	ffice	28f. Location (Stre City or Town,	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	hysiclan: To the best miner: On the basis of and manner sta	f examination and/or							

Medical Certification: To Be Completed by Physician/Medical Examiner

29b. Signature and itle of certifier

Director

Be Completed by Funeral

မ

Physician

/Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.

physician and s the burial-trans attending pt been signed by the should be detached certificate has be irector, page 2 s director this After t within 24 hours after death.

To the Funeral Director: A completely filled in by the formal completely filled in by the formal completely filled in by the formal completely filled in by the formal completely filled in by the formal completely filled in by the formal completely filled in by the formal completely filled in by the formal completely filled in the formal completely fi

3

State

Registrar

PAULINE 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DALEY- RICHARDS

MD

32. Registrar's Signature

DHMH 17 Rev 1/2001

29c. License number

10062895

1500 Pennsylvania Avenue

Hagerstown, MD 21742

29d. Date signed (Month, Day, Year)

AUGUST

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend item 25 per me g921 11-4-11 vt
Amend Item 2 per me g922,12719/2001 and Mental Hygien 0 | 0 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 07/28/2010 3. Time of Death **Physician** 7 /20 / 2010 Day 1:00 a M Adan Roberto Lemus /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital Montgomery 01ney If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Country)
Salvador Months Days Hours Min. 1XIM 2□ F 231-59-8567 41 03-10-1969 Director E1 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a, State 10b. County 1♥ Yes 2 No Director VA Fairfax Springfield 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22150 7320 Beverly Park Drive El Salvador Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: salvadoran If Yes, Give Year or Dates: 1XiYes 2□No \$ Specify:Hisp**ani**c 3 Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction 2nd Roofer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Lucia Lemus ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mirna Flora Lemus (Sister) 11477 Columbia Pike #B10 Silver Spring, MD 20904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 X Removal from State 4 □ Donation 5 □ Other (Specify) Family Cemetery San Miguel, El Salvador 08-08-10 22. Name and Address of Facility W.H. Bacon Funeral Home, Inc. of Funeral Se vide Licensee 3447 14th St. N.W. Washington, DC 20010 9/rt1. Enfer the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shool or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): CERTIFICATION APPROVED BY MEDICAL EXAMI Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛛 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Seizures 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 🛣 ER/Outpatient 3 ☐ DOA 1XXIYes -2XXIN Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The law requires that the death certificate be executed and attending physician a for use as the burial-Box 68760, P.0. signed by the a Division of Vital Records, certificate has birector, page 2 sl To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. p

28a-f show

ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

is marked other than

Termit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event

within 72 hours after death with

Baltimore, Maryland 21215-0036

State Registrar

Ghousia Sultana 31. Date filed (Month, Day, Year)

04 2010

30. Name and addess of person who completed cause of death atem 23a) (Type, Print)

(Check only one)

29b. Signature and title of certifier

12107 Heritage 32. Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D56691

29d. Date signed (Month. Day, Year)

July 29, 2010

Park Circle, Silver Spring, Maryland 20906

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 20 10 25895 State of Maryland / Department of Health and Mental Hygiene

			1- For State Registrar		Ce	rtificate (of Deati	h		R	teg. No.		
Physician/			1. Decedent's Name (First, Middle,Last)						Date of Dea Month	Day Ye	ar	3. Time of Death	
Medical Examiner			Eric Donald Ludvigsen 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death						July 29, 2	4c. County	of Death	1913 hrs	
			Route 482 North of Leisters Church Road 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County Carroll								oi Deali	,	
Fun	eral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Unde	er 1 Year If U	Inder 24Hrs	B. Date of Bi	rth(MM/DD/YYY	r) 9. Bir	thplace (State or
Dire	ctor		214-35-4487	1 M 2 F	1	8 y	rs. Month:	s Days Ho	ours Min	Jan. 3	1, 1992	Foreig Co	ⁿ ^{untn} Maryland
			Usual Residence of Decedent										
	ж апу		10a. State 10b. County		10c. City	, Town or Loc							10d. Inside City Limits 1 X Yes 2 No
yland	ouce.	힏	Maryland Ca	rroll		Westm	10f. Zip	_			l 0g. Citizen of W	hat Carr	
e Mar	or 28a-f show fied at once,	Director	410 Farm Cre	ek Rd.			101. Zip	21157			rog. Citizen or vv	USA	•
5-0036 ed within 72 hours after death with the Maryland tygiene.	ns 23a or 28a-f sho be notified at once		11. Marital Status	12. Was Dec	edent Ever in U	l.S. 13. V	Vas Decede		Origin? (Sr	pecify Yes or No	o- 14. Race		can Indian, Black,
leath v	or item must b	Funeral		arried Armed Fo				y Cuban, Mexic				e, etc.	
after o			3 Widowed 4 Div	vorced If Yes, Give Year		1	Yes 2	No spec	cify:		Specify:	Wh	ite
hours	other than "natural", the Medical Examiner	Completed by	15. Decedent's Education (Spe					Occupation (Gi			16b. Kind of Bu	ısiness/I	ndustry
36 in 72	han " lical l	plet	Elementary/Secondary (0-12)	College (1	-4 or 5+)		Stud	dent		N/A			
15-003 Ted withi Hygiene.	ther t	E O	17. Father's Name (First, Middle,	Last)			-		her's Name	(First, Middle,	Maiden Surname		
21215-0036 uld be filed within 7 Mental Hygiene.	marked o	Be	Donald R. Lud					Su	zanne	M. Rev	nolds	•	
9 9	is mar		19a. Informant's Name/Relations	hip (Type, Print)		19b. Maili	ing Address				nber, City or Tow	n, State	, Zip Code)
Z da da	tant: If item 27 is marked or other traumatic event,		Donald R. Ludv	igsen/Fath		410 1	Farm C	creek Ro	d., We		ter, MD	211	57
Baltimore, M permit. Pages 1 and 2 Department of Health	If ite		20a. Method of Disposition 1 Burial 2 Cremation	n 3 Removal fro		crematory or		ne of cemetery,		Date	20c. Location	- City or	Town, State
Fagornent			4 Donation 5 Other Sa	pecify:		rroll (Cremat	ion, Inc	08	/04/201	Hampst	ead	Maryland
Baltim permit. Pag Department	Important: injury or ot		21 Signature of Funeral Service	Licensee		22	Miles	Ad Trus person	Hor	ne and (Chapel,	P.A.	•
Physic		\dashv	23a. Part I. Enter the disease, or	complications that ca	used the death	. Do not enter	the mode o	SNINGEO of dying, such a	on Roll s cardiac o	r respiratory arr	minster, est, shock, or he	MD art	21157 Approximate Interval
/Med	ical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease a. Blunt Force Head Trauma										Between Onset and Death	
Exami	iner		or condition resulting in death)	Due to (or as a									
		L	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause										
		nine											
P	iţ.	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										I
760, icate be executed	physician and the burial - transit	la E	UNPENDED	d									
e be	ysicia burial	edical	IF FEMALE:								Lood Bata of	delline	
1876 tificat	as the	.≥	23b. Was decedent pregnant in the past 12 months?	ne 1 Live bi	utcome of preg rth		etal death	3 Ecto	opic pregna	incy	23d, Date of Month		yay Year
Box 68760 death certificate b	e attending for use as t	Sicis			ant at time of de	- db	Other (Spec	cify)					
. Be the des	by the a	Physician	Part II. Other significant condit	9 Unkno		esulting in the	underlying	cause given in	Part I	23e Did to	nbacco use contr	ibute to t	the cause of death?
P.O.	signed b	þ	Tak iii Gulor digiiii Gulia Gulia	torio contributing to	death bat not n	coditing in the	andenying	oddoc giveir iir	T GIV II.				ably 4 Unknown
ds,	s been si should b	Completed								24a. Was			topsy findings available
c law r	ha 2	ğ	_								rmed? c	leath?	ompletion of cause of
.	Description of Death (Check only one) 1 ✓ Yes 2 No 2 No 1 ✓ Yes 2 No								✓ Ye	s 2 No			
∕ita ysicia⊔	this certifi I director,	e B	examiner? 1 ✓ Yes 2 No	Allegaitet and	patient 2	ER/Outpatie		OA Other			Residence 6	/ Other:	Scene
of o	After the	-	27. Manner of Death	28a. Date of	of Injury	28b. Time of	f Injury 2	8c. Injury at Wo			now injury occurr		
ion tendu	tor: /	aţi.	1 Natural 5 Pend 2 ✓ Accident Inves		310	1900 hrs		1 Yes 2	✓ No	Dilver auto	truck collision	1	
24a. Was an autopsy performed? The part of the first of								tate)		r or Rural Route Number, City			
D ospital hours	is a set of the monoide												
29 A. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state (Check only one) 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the and manner stated.													
Tor	Com	Med	29b. Signature and title of certifie	and manner st				License numb		_	29d. Date sign		
WIL	,	211	Anna Ca	6	O.C.M.E.					July 30, 2010			
MyS		-	30. Name and address of person	who completed cause	e of death (Item	23a)							
J			Russell Alexander MD	Assistant M			1 Penn S	Street, Baltin	nore, Mi	21201			
	St	ate	31. Date filed (Month, Day, Year)	2010 32.5	gistrar's Signatu	ire /	ake						

		•	For State Registrar	State of Ma	aryland		tificate of D			giene Reg. No	2010	258	196
	Physicia Medic		1. Decedent's Name (First, Middle, Last					2. Date of Death Month July 27,		3. Time of 5:3	Death		
 }	Examin		4a. Facility Name (if not institution, give s		4b. City, Town, or	Location of Death	n	4c. County of Death					
	Funeral		Casey House 5. Social Security Number 6. Sex 1 \square M 2 \boxtimes F 0.0 Vrs				If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	th y, Year)	Montgomery h (, Year) 9. Birthplace (State or Foreign Country)			
	Director		Usual Residence of Decedent		90	Yrs.			8. Date of Bir (Month, Da 11/24	/191	9	Vier	
	laryland 3a-f sho ified at	Director	10a. State 10b. County Maryland Montg	jomery	10c. City, To	own or Loc		ilver Sp	оніна			10d. Inside Ci	ty Limits
	led within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	ral Dir	10e. Street and Number 1019 Cresthau				10f. Zip Code	20903	or our reg	10g. Cit	tizen of What Cou	untry?	
	death w items?	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S.	13. W	/as Decedent of His Yes, specify Cubar		pecify Yes or No- o Rican, etc.)		14. Race - Ameri Black, White	ican Indian,	
039	ırs after ıral", or I Examii	ed by	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 2 👿 N If Yes, Give Year or Dates.	Ю		☐ Yes 2 🛣 No				Specify:	Asia	n
215-0036	ייס 72 אסטר an "natu Medica	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Seconday (0-12)	de completed)		(Give k	ent's Usual Occupa ind of work done do NOT use retired)	ition uring most of wor	rking	16b. K	Kind of Business I	ndustry	
7	d withir Hygiene ther tha nt, the	Be Co	8 17. Father's Name (First, Middle, Last)	College (1-4 or 5+	-)		Homen		(m) 1 A a) 1 (s			Home	
Maryland	e fi	입	Nam	Le				18. Mother's Nar	ne (First, Middle, Huu	Huy			
Za	2 sho	1	19a. Informant's Name/Relationship (Type) Brian Tran - S	•			g Address (Street a. Cresthave			-			20903
timore,	ge 1 and 2 it of Healt if item 2 or other		20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗆		20b. Place ceme	e of Dispos etery, crem	sition (Name of atory or other place	e)	Date	20¢. Lo	ocation - City or 1	Town, State	
	t. Pag tmen tant: ijury		4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Funeral Service License)	Gate		Heaven Ce						Inc.
t	Depar Import any irr		Annedlane	Warke	'	32 11.	800 New H	lampshir	e Ave.,	Silv	ier Spri	ng, MD	
÷	Trysician:	8 19	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition								4	Approximat Interval Bet Onset and I	ween
	Medical Examiner		resulting in death)	Due to (or as a			on cancer						
=	, D #	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	consequenc	uence of):								
	execute an and ial-trans	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	consequenc	uence of):								
09/99	icate be executed g physician and is the burial-transi	ledical		d									
X DO	th certifi tending or use æ	ian/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live Birth 2	: 🗌 Fetal de		Ectopic pregnancy	,			23d. Date of deliv		6
J. BOX	the dea by the a ached fe	Physician/N	1 Yes 2 X No 9 Unknown	4 ☐ Pregnant at t 9 ☐ Unknown	time of deat	h 5∟	Other (specify)				Month	Day \	/ear
S, P.	ires that signed Id be del	ρ	Part II. Other significant conditions con	ntributing to death but	t not resultir	ng in the ur	derlying cause give	en in Part I.			use contribute to t		
Vital Records,	law requass beer 2 shou	Completed							24a. Was autor	sy		opsy findings a	available ause of
= Ke	an: The tificate h or, page	0	25. Was case referred to medical				26 Pla	ce of Death (Che	1 🗌 Yes	rmed? 2 X No	death? o 1 Yes	2 🗆 No	
<u> </u>	Physicia this cer al direct	To B	1 Li Yes 2 Lig No	lospital: 1 Inpatier 28a. Date of injury		_	3 DOA Other	r: 4 🗆 Nursing H		lence 6	Other (Specif	y) Hosp	pice
0 00	ending Path.	Certificate:	27. Manner of Death 1 ↑ Natural 2 ↑ Accident Investigation	Year) 28t	28b. Time of injury 28c. Injury at work? M 28c. Injury at 28d. Describe			28d. Describe h	how injury occurred				
DIVISION OF	al or Atte		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At hobididing, etc. (Specify)			me, farm, street, factory, office 28f. Location (St. City or Town					treet and Number or Rural Route Number, n, State)		
 :	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. within 24 hours after death. The Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 L Medical Examin	cian: To the best of m	amination and	d/or investi	gation, in my opinior	n, death occurred a	at the time, date a	nd place	, and due to the ca	ause(s) and ma	nner stated.
_	To the within To the compl	Σ	only one) 3 Certifying Nurse 29b. Signature and title of certifier	Practioner: to the be	est of my kno	owieage, ae	29c, License				s) and manner as s te signed (Month,		
	7		30. Name and address of person who co	empleted cause of dea	ath (Item 23a	رب a) (Type, Pr		R120698			July 27,	, 2010	
			Nicole Christens 31. Date filed (Month, Day, Year)	son, CRNP,	6001	Munc	aster Mil	l Road,	Rockvil	le,	Marylan	d	
	Stat Registra	_	AUG 02 201	32 Registrar	a signature	pa	the .						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra 25897 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2010 Month # Physician/ 1504 Medical Facility Name (if not institution, give street and number) Town, or Location of Death **Examiner** County of Death Age (In yrs. last birthday) If Unde If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ★ M 2 □ F Min. Hours Barrymore, MD 215-14-0868 87 Yrs 1(49°2°77°41**'9**°2'2 **Director** Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director MD Annapolis 1 🗆 Yes 2 🄀 No Anne Arundel 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21403 515 Hillsmere USA Drive Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 X Yes 2 □ No If Yes, Give Vear or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. White WWII "natural", 3 Widowed 4 Divorced Specify: Completed permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
CPA 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Conjege (1-4 or 5+) Private Practice Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lillian Sklar Oscar Lobe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Natalie K. Lobe 515 Hillsmere Drive Annapolis, MD 21403 Spouse 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Hillcrest Cemetery 08/01/2010 Annapolis, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility 12 Ridgely Annapolis, als Hardesty Funeral Home P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Çause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) **Director.** After this certificate has been signed by the attending physician and if in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death 2 No g Unknown Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes completed filled in by the funeral director, 25. Was case referred to medica æ 26. Place of Death (Check only one) Other: 1 Yes 2 မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Dear 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. De scribe how injury occurred work? 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State)

State

31. Date filed (MonAUGY) 3 2010 Registrar

29a. Certifier (Check

29b. Signature and tit

Erika M

e of certifie

Benns M.D.

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 139 Old Solomons Island Road Annapolis, MD 21401 jistrar's Signatu

29d. Date signed (Month, Day, Year)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Day Year John Ray Lynch 2010 Medical August 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince Georges 23400 Christ Church Rd. Aquasco Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Virginia 8. Date of Birth **Funeral** 1 😿 M 2 🗆 F Months Days Hours Min. Director 64 231-58-6979 01/28/1946 Usual Residence of Decedent show or 28a-f show notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 🗌 Yes 2 😾 No Maryland Prince Georges Aquasco 10e. Street and Numbe ö 10f. Zip Code 10g. Citizen of What Country? and Mental Hygiene. is marked other than "natural", or items 23a or aumatic event, the Medical Examiner must be r Funeral 23400 Christ Church Rd. 20608 USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Was Decedent _vo. Armed Forces? 1 ☐ Yes 2 🛣 No Black, White, etc. 1 Never Married 2 Married ş filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Engineer Marine Engineering Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. traumatic Ralph Henry Lynch Mary Elizabeth Daniels 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Colleen M. Lynch/Wife 23400 Christ Church Rd., Aguasco, MD 20608 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Brinsfield-Echols Cr. 08/11/2010 4 ☐ Donation 5 ☐ Other (Specify) Charlotte Hall, MD 22. Name and Address of FacilitBrinsfield-Echols Fun. Home, PA 21. Signature of Funeral Service Lice 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final adenocarcinoma of the distalileum Physician disease or condition months Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of and -transit Exam The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): physician a s the burial-1 Medical Box 68760 attending p IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown signed by t d be detach Division of Vital Records, P.O. Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2 s autons certificate 1 Yes 2 No Yes 2 No To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director; I Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 1 No Other: 1 Yes ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) US6024 August 10 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Prince Frederick Kenneth L. Abbott 20678 Suite 110 110 Hospital Road

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

AUG 11

oistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 25899 Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Day Month 2010 Gurbach Lanczky 9 Teresa August 4:32 a.M. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Taylor Farm Assisted Living Bushwood St. Mary's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F (Month, Day, Year) 01/10/1915 Director 95 104-20-8803 Vermont Usual Residence of Decedent show 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland | St. Mary's Hollywood 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 43567 Drum Cliff Road 20636 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Force Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: "natural" 3 X Widowed 4 Divorced White Year or Dates of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Window Designer Candy Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Vincent Gurbach Anna Kovacs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Van Maastricht/Daughter 43567 Drum Cliff Road, Hollywood, MD Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Cre 08/10/2010 Charlotte Hall, MD Signature Funeral Servic Licensee

Edward N. Erinstield, 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Jr. M00052 22955 Hollywood Road, Leonardtown, MD 20650 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on wach line Immediate Cause (Final Can Physician disease or condition resulting in death) ue to (or as a consequence of) Medical Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury Just to for es a nonsecuenne of that the death certificate be executed the attending physician and hed for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown q Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ the Hospital or Attending Physician: The law requires Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe After this certificate 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Living ျာ 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No **X** Natural 5 Pending Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatu and title of certi 29d. Date signed (Month, Day, Year) 2

State Registrar

DHMH 17 Rev 7/2009

25365 Point Lookout Road, Leonardtown, MD

20650

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

Boyd.

William D.

AUG 12

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 4:00 P M William Paul Ludwig Medical Examiner 4a. Facility Name (if not institution, give street and number) 4c. County of Death omico al Security Numbe 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 🗓 M 2 🗆 F (Month, Day,) 212-16-3990 Director Marvländ Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Wicomico Salisbury 10f. Zip Code 10e. Street and Numbe 10g, Citizen of What Country? Funeral 21804 1006 Riverhouse Rd Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married 1 X Yes 2 □ No US
If Yes, GiveArmy Air
Year or Dates. Force William Ludwigge Baltimore, Maryland 21205-0036 Completed by 1 ☐ Yes 2 X No Specify: Specify: White 3 H Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Carroll's Jewelers Hand Engraver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Edna Ramsev Paul William Ludwig 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 146 Hunter's Way, Salisbury, Md 21801 William D. Ludwig son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State 8 4 2010 Salisbury Crematory Salisbury, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
HOIIOway Funeral Home P.A.
501 Snow Hill Rd., Salisbury, Maryland 21804 art 1. Enter the disease, or complicatio d the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest shock, or heart failure. List only one car Interval Between Onset and Death Immediate Cause (Final BA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to mini adiate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for sels consequence of the attending physician and hed for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Other (specify) Pregnant at time of death Yes 2 No To the Hospital or Attending Physician: The law requires that the der within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached it 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 🗌 Yes Completed 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 24a. Was an autopsy 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence Hospital: HOSPICA မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury 28c. Injury at Certificate: injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated contributing Number Production of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the name(n) and manner as stated. 29b. Signature and tit of certifier 29d. Date signed (Month, Day, Year)

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

WAN

D0058410

21802

1771

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25901 State
Registra AMEND#23a(b)perMD8/4/10, EMW, MbCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 31,2010 Year F. Carole Martin 0227 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Number 059-32-5131 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 🗆 M 2 🕱 F Hours (Month, Day, Director 70 Usual Residence of Decedent Termit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Silver Spring 1 Yes 2 No 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? 15208 Haslemere Court Completed by Funeral 20906 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 XNo Specify: 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CONTRACT Manager 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Montgomery County Elementary/Seconday (0-12) College (1-4 or 5+) Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Herman Fletcher Vernice Ponton 19b Mailing Address (Street and Number or Flural Route Number, City or Town, State, Zip Code) 20906 15208 Haslemere Court Silver Spring, Md ^{19a,} Informant's Name/Relationship *(Type, Print)* Edward E.Martin/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛭 Cremation 3 ☐ Removal from State Chesapeake Crem. 8/04/2010 4 ☐ Donation 5 ☐ Other (Specify Beltsville, Md. 21. Signature of meral Service Lice PHATITE OF THE NALDI FUNERAL SERVICE, P.A. 9241 Columbia bLvd.Silver Spring, Md20910 23a. Part 1. Enter the Alisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMO NIA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Breast Cancer with Brain Metastasis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence by) sate has been signed by the attending physician and page 2 should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 C Ectopic pregnancy in the past 12 months?
1 Yes 2 2 No Month Year Day 5 Other (specify) 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🕏 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No To the Hospital or Attending Physician.

-within 24 hours after death.

Oro the Funeral Directo: After this certifiants. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔽 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation in my original death account of the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Seo, us 8/2/10 P0057124 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 10110 Molecular Dr.#206 Rockville,Md 20850 Truong Boa

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

AUG 04

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 25902 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 1Day 2010 ear Bernard Margolius 12:15 P M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda <u>Montgomery</u> Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Min. Hours 577-54-5281 1 □xM 2 □ F 96 No Vonth, Dep Year) 1913 Washington, DC Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Broward Pompano Beach 1 🔀 Yes 2 🗌 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4110 Palm Aire_Drive West_#101A 33069 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces' Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 XNo 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Govenment Attorney 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wolf Margolius Jenny Cohen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alan Margolius/Son 103 Lake Street, Gaithersburg, Maryland 20878 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/4/2010_ Judean Mem. Gardens Olney, Maryland Signature of Funeral Service Licensee 22. Name and Ad Poly AFT dity Sagel Funeral Direction, Inc MO1597 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death disease or condition resulting in death) Congestive Heart Failure Due to (or as a consequence of): Atrial Fibrillation Due to (or as a consequence of): Due to (or as a consequence of): 23b. Was decedent pregnant

Physician Medical Examiner

Physician/

Medical

10a. State

Director

Funeral

Completed by

Be

ပ

Examiner

Funeral

Director

3a or 28a-f sh be notified a

"natural", or items 23a o

peorit: Page 1 and 2 shours ...
Department of Health and Mental Hygrens.
Important: If item 27 is marked other than "natura.,
... other traumatic event, the Medical Exp.

should be filed within 72 hours after death with the Maryland n and Mental Hyglene. ' is marked other than "natural", or items 93a مه 98مــه ماس

Baltimore, Maryland 21215-0036

DIVISION OF VITAI RECORDS, P.O. Box 68760

has h

24 hours after deat Funeral Director:

within 2

ρ

completed filled in by

Be

၉

Certificate:

Medical

Se wentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury tor: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-trans that initiated events resulting in death) Last Completed by Physician/Medical

IF FEMALE:

1 🗌 Yes

3 Suicide

29b. Signatur

4 Homicide

in the past 12 months?
1 ☐ Yes 2 ☐ No

23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death

4 ☐ Pregnant : 9 ☐ Unknown

Ectopic pregnancy Pregnant at time of death 5 Other (specify)

23d. Date of delivery Month Day

Year 23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes ∠ L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performed?

1 Tyes

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

2 X No 3 ☐ Probably 4 ☐ Unknown

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2X No 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred injury Natural 5 Pending Accident Investigation

6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined

😾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

29d. Date signed (Month, Day, Year) 8

s of person who completed cause of death (Item 23a) (Type, Print) Name a

iled (Month, Day, Year) AUG 04 2010

MD 8600 Old Georgetown Road, Bethesda, Maryland 20817 Registrar's Signature

State Registrar

State of Maryland / Department of Health and Mental Hygien 20 25903 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** 30 Day 2010 July 1:40 A M Regina R. Moulden /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Mandrin Hospice House Harwood If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. | May 29 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Year)971 Maryland 1 ☐ M 2 🔀 F 39 216-94-7112 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm. Medical Evantial and once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Director Anne Arundel Annapolis Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21401 USA 40 Julianna Circle East Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed by Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Anne Arundel Co. Elementary/Secondary (0-12) College (1-4or 5+) 12th 0 Custodian Board of Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Moulden Rosilee Creek ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 40 Julianna Circle East Annapolis, Md. Rosilee Franklin(Mother) 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Chews U.M. Church 8-4-10 West River, Md. 4 ☐ Donation 5 ☐ Other (Specify) Miname Resease of Scin Sons Mortuary, P.A. 21. Signature of Funeral Service Licensee Larry & Seese 821 West St. Annapolis, Md. 21401 MOOSE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician スト anLer 189 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed 24 hours after death. Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 \(\subseteq \text{Ectopic pregnancy} \) Month Day Year 5 ☐ Other (specify) been signed by the a should be detached 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 1 □Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1☐Yes 2☑No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident neral Director: , filled in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) within 2 er of certifier 29d. Date signed (Month, Day, Year) 29b. Signatu 30. Name and ad ress of pe or w o completed cause of death (Item 23a) (Type, Print) 9 00 31. Date filed (Month Redistrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TTEM#5perFH, G906, 8/30/2010, WS
State of Maryland / Department of Health and Mental Hygiene 25904 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2<u>010</u> Physician/ Month Edward Joseph Morgan ugust 8:58 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 38910 Foley Mattingly Rd. Mechanicsville St. Mary's 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 XM 2 □ F Months Davs Hours (Month, Day, Year) 215-54-1 Director 62 01/26/1948 Maryland Usual Residence of Decedent 28a-f show 10b. County at 10a. State 10c. City, Town or Location the Maryland 10d. Inside City Limits Director ms 23a or 28a-f s must be notified 1 Yes 2 No Maryland St. Mary's Mechanicsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral permit. Page 1 and 2 should be filed within 72 hours after death with 38910 Foley Mattingly Rd. 20659 USA items ? 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status Race - American Indian, Black, White, etc. Examiner Armed Forces?
1 ☐ Yes 2 X No Yes, specify Cuban, Mexican, Puerto Rican, etc. ō Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give "natural", 3 ☐ Widowed 4 ☐ Divorced Year or Dates ed other than "nature event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Carpenter Carpentry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental F tem 27 is marked of other traumatic ever 2 Joseph Johnson Morgan Cora Burch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Morgan/Spouse 38910 Foley Mattingly Rd., Mechanicsville, MD20659 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ō Important: If it any injury or o once. 1 Burial 2XXCremation 3 Removal from State August 9, Charlotte Hall, MD 22. Name and Address of Facility Brinsfield—Echols Funeral Home 4 Donation 5 Other (Specify) Brinsfield-Echols Crem. 21. Signature of Funeral Service License 30195 Three Notch Rd., Charlotte Hall, MD20622 23a-Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and D ath etustatic Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Per tension attending physician and for use as the burial-tran that initiated events Hospital or Attending Physician: The law requires that the death certificate be execu 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and resulting in death) Last Due to (r as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Other (specify) Day Year ed by the a detached f 9 Unknown 9 Unknown To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detact. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 □ Probably 4 □ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an autopsy performe Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: ဂ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Man of Death 28c. Injury at work?
1 Yes 2 No 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred Natural iniury 5 Pending 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

St. Mary's Medical Arts - 22650 Cedar Lane Ct. ate H 31. Date filed (Month, Day, Year) 32. Regist 2010 b

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D 62213

9

eonardtown

MD

			For State Registrar	e of Maryland		artment of F <i>tificate of L</i>		and Mental H	ygien Reg. N	/ ! ! ! ! !	25905
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)					2. Date of I)eath		3. Time of Death
	Medic	cal	French Everett Me 4a. Facility Name (if not institution, give street and	dley		4b. City, Town, or	I sastian at	Augus	t 9,	2010	12:20 p.₩.
	Examin	ier	Chesapeake Shores Nur	,		Lexingto			- 1	c. County of Death St. Mary *	
Ü	Funeral Director		5. Social Security Number 6. Sex 1 X M 2 C	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	8. Date of E Min. (Month, I 10/08	Birth Day, Year)	9. Birth Court Virg	nplace (State or Foreign ntry) sinia
3	how at	Ž	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Loc	cation					10d. Inside City Limits
Ach	Ba-fs tified	Director	Maryland St. Mary's		ngton						1 ☐ Yes 2 🛣 No
4	a or 2	Ö	10e. Street and Number		8	10f. Zip Code			10g. C	Citizen of What Cou	intry?
4	ns 23. must	Funeral	21744 North Essex Dri			20653				ited Stat	es
5-0036	permit. rage I am 2. should be made whith 1.2 hours ared death with the Maryland permit. Tage I am 2. should be made Marial Hyglene. Important: If item 2.7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Never Married 2 Married 1 If Yes	Decedent Ever in U.S. d Forces? Yes 2 XNo s, Give or Dates.	lf lf	Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 🛣 No	n, Mexican,	in? (Specify Yes or No Puerto Rican, etc.)	D-	14. Race - Ameri Black, White, Specify: Whi	etc.
-c	"natu	plete	15. Decedent's Education (Specify only highest grade comple		16a. Deced	ent's Usual Occupa	ation	of working	16b.	Kind of Business In	
	than than	Completed	Elementary/Seconday (0-12) College	ge (1-4 or 5+)	life. DO	O NOT use retired)	uning most t	or working	1,,	C	
ב ב	Hygie other /ent, t	B B	17. Father's Name (First, Middle, Last)		Fore	nan	18. Mother	r's Name (First, Middi		S. Govern	ment
yland g kafig	Menta arked aric ev	욘	John Medley				Minni	ie King			
Mar	raum		19a. Informant's Name/Relationship (Type, Print)		ı			or Rural Route Numi			Code)
e, F	Health Health tem 2: other t		Doug Medley/Son 20a. Method of Disposition	20b Pia		Box 862,	Holly	wood, MD	2063	36 Location - City or To	Outro Stato
E DE	nt: If i		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	from State ce	metery, crem	natory or other place emorial	´ .	8/13/2010		*	, _
saitimol	epartm nporta ny inju		21. Sign deral Service Licenses	/ 11111				Brinsfie:			
	70 = # O		Edward N. Brinstie L 23a. Part 1. Enter the disease, or complications t					Road, Le		dtown, MD	
	nysician/	8 77	shock, or heart failure. List only one cause of Immediate Cause (Final disease or condition resulting in death)	on each line.	1 A 2	tem,	Dises	and a contraction of the contrac	211031,		Approximate Interval Between Onset and Death
	Medical Examiner		C	e to (or as a consequ	nce of):	Ness	+1	millip	9		LACA PS
-	. ±	iner	cause. Enter Underlying	e to (or as a conseque	ence of):	1	0,				10000
cate be executed	physician and s the burial-transit	edical Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	e to (or as a conseque	ence of):	id Ney	di	SPASE	<u></u>		YEARS
Ste be	hysici the bu	dica	d								
ertifica	ding p		IF FEMALE: 23b. Was decedent pregnant 23c. If yes	, outcome of pregnan	cv						
or Attending Physician: The law requires that the death certifi	been signed by the attending should be detached for use as	Physician/M	in the past 12 months?	Live Birth 2 🗀 Fetal Pregnant at time of de Unknown	death 3 🗌	Ectopic pregnance Other (specify)	у			23d. Date of deliv Month	Day Year
uires that 1	n signed build be deta	by	Part II. Other significant conditions contributing	to death but not resul	Iting in the ur	nderlying cause giv	en in Part I.			use contribute to the	he cause of death?
aw requires	as bee	Completed						24a. Wa	s an opsy	24b. Were auto	psy findings available impletion of cause of
r he	cate h							1 🗆 Yes	formed?	death?	2 🗆 No
sician	certif	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	4 D 4	'D/O-1	Othe	r \ /	(Check only one)			
a Physical Control	er this neral d	te: To	27. Manner of Death 28a. D	1 ☐ Inpatient 2 ☐ E Date of injury 2 Month, Day, Year)	:H/Outpatient 28b. Time of injury	28c. Injury	at	sing Home 5 Res 28d. Describe			2
endin	eath. or; Aff the fur	ifica	Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	wonth, bay, rear)	ii ijui y	M 1 🗆	Yes 2 1	40			
tal or At	rs after d al Direct ed in by	al Certificate:	4 Homicide determined 28e. P	lace of Injury - At hom uilding, etc. (Specify)	ne, farm, stre	et, factory, office		28f. Location City or To		nd Number or Rurai e)	Route Number,
the Hospital	within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2.	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To t 2 Medical Examiner: On the 3 Certifying Nurse Praction	basis of examination a	and/or investi	gation, in my opinio	n, death occi	urred at the time, date	and plac	e, and due to the ca	use(s) and manner stated.
To t	To 1		29b. Signature and title of certifier		CO. C	29c. License	number	20	29d. Da	ate signed (Month,	Day, Year)
me	,		30. Name and address of person who completed	cause of death (Item 2	23a) (Type, Pr	1KO7	لككر		0/	11/10	
,,			EllaBeth A. FRy man 31. Date filed (Month, Day, Year)	21412 2. R gistrar's Signatur	SRE	A+ Mill	s Red	- Lexing +	m	PARK, 1	N. 20653
	Stat Registra		AUG 1 2 2010	2. Registrar's Signatur	D. 4	all					

			ForState	State of Maryl				ientai Hy	giene		
			Registrar		Cer	tificate of L	Death		Reg. No.	2010	25906
	Physicia	ın/	1. Decedent's Name (First, Middle, La					2. Date of De Month	Day	Year	3. Time of Death
-74-	Medic		Dolores Marie 4a. Facility Name (If not institution, giv	Mercer		4h City Tayya a	r Location of Death	August		2010	1:24 p.mM
	Examin	er	St. Mary's Hospi			Leonard				County of Death Mary	
	Funeral		5. Social Security Number 6, 5	Sex 7. Age (In v	rs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th	9. Birth	place (State or Foreign
	Director		218-24-02/9	1 □ M 2 🗓 F 7	79 Yrs.	Months Days	Hours Min.	10/18/	y, Year) 1930	Cou	sylvania
	d how it	_	Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or Lo	ootion					40.1 1.14 02.11.2
	ırylan a-f sh ied a	cto			•						10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	or 28;	Director	Maryland St. Mary 10e. Street and Number	's Lex	xington	Park 10f. Zip Code		1	10a Citia	ten of What Cou	
	with the 23a cast be	əral	22084 Fox Ridge	Road		20653			Ü	ed State	•
	eath tems	Funeral	11. Marital Status	12. Was Decedent Ever in	n U.S. 13. V		ispanic Origin? (Spe In, Mexican, Puerto			4. Race - Ameri	can Indian,
98	fter d ", or i amin	by	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 █XNo If Yes, Give		Yes, specify Cuba		Rican, etc.)		Black, White,	etc.
ĕ	tural al Ex	Completed	3 Widowed 4 Divorced	Year or Dates.						wh:	Lte
7.	72 hc n "na Aedic	nple	15. Decedent's (Specify only highest g	rade completed)	(Give I	lent's Usual Occup kind of work done c D NOT use retired)	ation during most of worki	ng	16b. Kin	d of Business Ir	ndustry
212	vithin jiene. er tha the N	ပိ	Elementary/Seconday (0-12)	College (1-4 or 5+)		Manager			 Reta	ail Sale	es
שָׁל	filed vall Hyg	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle,			
ylaı	ld be Menta arked atic e	욘	Frank James				Gladys Y	aunger			
Mar	shour and is m		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street a	and Number or Rura	l Route Numbe	r, City or T	own, State, Zip	Code)
€	and 2 lealth sm 27 her to		Charlene Knott/Da				Great Mi				
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	☐ Removal from State ⊤	Ob. Place of Dispo cemetery cren mmaculat	sition (Name of natory or other plac e Heart	:e)	Date		ation - City or T	
華	urtmer artant ortant njury		4 Donation 5 Other (Spec	10	of Mary (<u>lemetery</u>	08/14				ark, MD
Ba	Deperment of the perment f the perment of the perment of the permet of th		21. Laward N. Brins	field, Jr. MO	00052 2	. Name and Addres 2955 Ho 1 1	^{ss of Facility} Bri Lywood Roa	nsfield ad, Leo	Fune nardt	eral Hon own, MI	ne, P.A. 20650
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	iplications that caused the cone cause on each line.							Approximate Interval Between
	Physician/	ì	Immediate Cause (Final disease or condition	· Fatal	Cardiac	Parth	who a				Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a cons	sequence of):	//					
		Jer	Securifically flat non-ditions if any, leading to immediate	Due to (or as a cons	seguence of):	-					Years
	ansit	edical Examiner	cause. Enter Underlying Cause (Disease or iinjury	_	,-						
	icate be executed I physician and s the burial-transit	EX	that initiated events resulting in death) Last	Due to (or as a cons	sequence of):			_			
2092	te be nysicia ne bur	dica		d							
876	tifical ing ph as th		IF FEMALE:						_	11,445	
Box 68	th cer ttendi	Physician/M	23b. Was decedent pregnant in the past 12 pronths?	23c. If yes, outcome of pre	Fetal death 3	Ectopic pregnanc	:y		2:	3d. Date of deliv	,
B	e dea the a	ysic	1 ☐ Yes 2 No 9 ☐ Unknown	4 ☐ Pregnant at time 9 ☐ Unknown	of death 5 ∟	Other (specify)				Month	Day Year
P.O.	hat the ed by detac	Y Ph	Part II. Other significant conditions	contributing to death but not	t resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco us	e contribute to t	he cause of death?
√ <u>s</u>	uires t sign Id be	d by				-		1 🗆 ,	Yes 2	No 3□Pro	bably 4 🗆 Unknown
Scord	v requ	olete						24a. Was a	an		ppsy findings available
、oceら Records,	he lay te hay age 2	Completed							rmed?	prior to co death? 1 ☐ Yes	ompletion of cause of
al	ian: T	BeC	25. Was case referred to medical			26. Pla	ace of Death (Check	only one)	2 No	1 LI Yes	2 L No
Vital	hysic nis ce	10	examiner? 1 Yes 2 No	Hospital: 1 lnpatient 2	ER/Outpatien	t 3 🗆 DOA Othe	er: 4 Nursing Ho	me 5 Resid	dence 6	Other (Specifi	v)
- Jo	ing P	ate:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of injury (Month, Day, Year,	28b. Time of injury	28c. Injury work	?	28d. Describe h	ow injury	occurred	
Si iš	ttend death stor: / the f	Certificate:	2 ☐ Accident Investigatio 3 ☐ Suicide 6 ☐ Could not t	ne l			Yes 2 ☐ No				
Division	I or A		4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	at nome, tarm, sire ecify)	et, ractory, office		28f. Location (S City or Tow		Number or Rura	I Route Number,
	pita Surs eral fille	cal		vsician: To the best of my kn	ation and/or invest	gation, in my opinio	n, death occurred at	the time, date a	nd place, a	ind due to the ca	use(s) and manner stated.
	Hos 24 hc Fun	교			ام حداد دارید سیاری دی کر	and the second set the second		and due to the	o calledel	-r	
	To the Hos within 24 hd To the Fund completed	Medical		se Practioner: To the best o	or my knowledge, d	29c, License				signed (Month,	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		only one) 3 Certifying Nur	se Practioner: To the best o	my knowledge, d	29c, License	number				
•			only one) 3 Certifying Nur	completed cause of death (i	MA Item 23a) (Type, P	29c, License	number 06289	3			
5 RM			only one) 3 Certifying Nur 29b. Signature and title of certifier Picket 30. Name and address of person who Mirchael Somon	completed cause of death (i	MA Item 23a) (Type, P.	29c, License	number 06289	3			
•		e	only one) 3 Certifying Nur 29b. Signature and title of certifier 200. Name and address of person who	completed cause of death (l	MA Item 23a) (Type, P.	29c, License	number	3			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 25907 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^{Day} 20<u>10</u> August 1 Virginia Louise Moniz 12:30 P [™] Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X XF Days Hours 023-26-9673 Director 02/08/1934 Massachusetts Yrs 76 Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Maryland Prince George's Ft. Washington 1 Yes 2NX No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 7104 Bock Road 20744 USA items ; 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ò 1 Never Married 2 Married ò 1 ☐ Yes 2x x No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: 'natural", Completed 3XWidowed 4 Divorced White the Medical Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) than Elementary/Seconday (0-12) College (1-4 or 5+) alth and Mental Hygiene.
27 is marked other than raumatic event, the N Physical Therapist vears Medical Be permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othv any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ပ Adolphe Adolphe John Twardowski Stella Swierad 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John C. Moniz 108 Adams Avenue Alexandria, Virginia 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Kalas Crematory Date 20c. Location - City or Town, State 1 ☐ Burial 2 🗵 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 8/3/2010 Edgewater, Maryland 21. Signatur unera Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon HIII Rd. Oxon Hill, Maryland 20745 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Orset ap Deat Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to for as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery signed by the atter in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Unknown Dav Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 24a. was an autopsy performed?

1 Yes 2 A No certificate has 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? in 24 hours atter ceau... he Funeral Director: After this of noleted filled in by the funeral dire 2 🔀 No Other: Certificate: To 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? Accident 2 🗌 No Investigation

Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number City or Town, State) Medical

State

Registrar

29a, Certifier

29b. Signature and title of certifier

person who completed cause of death (Item 23a) (Type, Print)

Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 25908 State of Maryland / Department of Health and Mental Hygien ? Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 152 PM JOID Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death MITMORE If Under 1 Year | If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Month, Day, Country) N.J. Director Usual Residence of Decedent 28a-f show 10c. City, Town or Location filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f shor Examiner must be notified at 10a. State 10d. Inside City Limits Director Wood bridge 1 🗌 Yes 2 📈 No 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 I Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married 2 No Maryland 21215-0036 Black 1 Yes 2 No Specify. permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important, If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exal Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Intormation Technology Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sur. ည 19b. Mailing Address (S. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 🗌 B -31-2010 4 Donation 5 Other (Speci 22. Name and Address of Facility Faith Signatur uneral Se MO1576 Allen town Rd #107 20746 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure List only one cause on each line. 23a, Part 1, Enter the diseas Approximate Interval Between Immediate Cause (Final Onset and Death Physician, disease or condition Medical resulting in death) Examiner Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner to (or as a consequence of) To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last consequence of Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE . If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year 5 Other (specify) Month Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? After this certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 **X** No 1 Yes ျာ 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work? 2 🗌 No Accident Investigation within 24 hours after deatl To the Funeral Director. Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature nd title of certific 29d. Date signed (Month, Day, Year) 2010 who completed cause of death (Item 23a) (Type, Print JUC 's Signat State 3 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 0 | 0 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ William Huffington Mariner 201 Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City Town, or Location of Death 4c. County of Death 5) Mra Funeral 215–20–1596 Year . Date of Birth If Under Birthplace (State or Foreign Country) 1 🕅 M 2 🗆 F Months Min 83 **Director** Maryland Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Mediral Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Wicomico 1 Yes 2 No Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 910 South Park Drive 21804 USA 11 Manital Status 12. Was Decedent Ever in LLS Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Š Black, White, etc. 1 ☐ Never Married 2 X Married Maryland 21215-0036 If Yes Give 1 ☐ Yes 2X No Specify. white Completed 3 Divorced 4 Divorced Army Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) production Dresser Industries Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harvey W. Mariner Sr. Julia Huffington 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 910 South Park Dr., Salisbury, MD 21804 Doris Mariner/spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Allen Cemetery Date 20c. Location - City or Town, State 1 🕅 Burial 2 🗌 Cremation 3 🗌 Removal from State 8/5/2010 4 ☐ Donation 5 ☐ Other (Specify) Allen, MD 21. Signature of Funeral Service Licenses Molloway Funeral Home Professional Ass 501 Snow Hill Rd., Salisbury, MD 21804 Association 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ PRRBBROVASCULAR disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) burial-trans Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 the IF FEMALE: asn 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy for 5 Other (specify) Pregnant at time of death Month Day Year 9 Unknown detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires t within 24 hours after death.
To the Funeral Director: After this certificate has been sign gonnieted filled in by the funeral director, page 2 should be 1 🗌 Yes 2/ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed Yes 2 death? 2 No 1 Tes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence မ HOSPICIE 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of eath Certificate: 28b. Time of 28c. Injury at Natural iniury 5 Pending work? Accident 2 🗆 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the basis of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner stated. let the time, date and place, and due to the 10058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) th, Pay, Year) AUG () 31. Date filed (Month Régistrar's Signature State 2010 Registrar

State of Maryland / Department of Health and Mental Hygienes Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Dav Year $\mathbf{P}^{\,\mathsf{M}}$ John C. New 07 10:30 /Medical 28 2010 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Silver Spring
Under 1 Year | If Under 24 Hrs. <u>Riderwood Village Nursing Facility</u> Montgomery Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1**½** M 2□ F Director 498-14-9481 08/09/1920 Missouri Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ral", or items 23a or 28a-f show Examiner must be notified at Director 1X Yes 2 □ No MD Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with then of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or: Funeral 3160 Gracefield Road 20904 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1⊠Yes 2□No If Yes, Give 1943 Year or Dates: 1944 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Completed by 3 ₩ Widowed 4 □ Divorced White er than "natura , the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Aeronautical Engineer Federal Government event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be : If Item 27 is marked or other traumatic ev မ George New Alexia Sligh 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Lowry - Daughter 511 N. Columbus Street, Alexandria, VA 22314 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any injury or ot 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 07/31/2010 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ft. Lincoln Funeral Home, Inc. 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20722 Brentwood, MD Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Pneumonia **Medical** Due to (or as a consequence of): _xaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-tra Due to (or as a consequence of) $New_{J}N_{M} 8/9/2o$ Division of Vital Records, P.O. Box 68760, signed by the attending physician I be detached for use as the buris Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> Alzheimers Disease 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? /es 2**X** No After this certificate 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🔀 Natural 5 Pending investigation To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20904 Andrew Kundrat, MD 8110 Gracefield Road Silver Spring, MD 31. Date filed (Month, Day, Year) State AUG 0 3 2010

DHMH 17 Rev 1/200

Registrar

			For State Registrar	State of Ma		epartme <i>Certifica</i>				ien 🔏 🚺	10	25911
			Decedent's Name (First, Middle,	Last)					2. Date of Deat	h	Year	3. Time of Death
	Physici /Medio		Robert James O'			1 41 07			July 23,			4:00 p
	Examin	er	4a. Facility Name (If not institution, Randolph Hills		mo		; lown, or Lo eaton	ocation of Death			ty of Death	
and the second	Funeral		-		e (In yrs. last birth	nday) If Unde	r 1 Year	f Under 24 Hrs.	8. Date of Birth		tgomery 9. Birth	place (State or Foreign
	Director		216-24-9935	1 X M 2□ F 82	Υ	rs. Months	Days	Hours Min.	June 22,		Mary	ntry) Land
	pu »		Usual Residence of Decedent		10c. City, Town	or Location						10d. Inside City Limits
	laryla shov	ė	10a. State 10b. County									1 ☐Yes 2X☐ No
	the M	Director	Maryland Mont	gomery	Roc	kville	p Code			0g. Citizen of	f What Cou	ntry?
	3a or	i Di	5904 Spaatz Place				2085	1		US	A	
	death	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Dece	edent of Hisp	panic Origin? (Sp Mexican, Puerto	ecify Yes or No-			can Indian,
936	be filed within 72 hours after death with the Maryland rtal Hyglene. ed other than "natural", or items 23a or 28a-f show event, Ite Medical Evarilizar must be inofffied at	by	1 Never Married 2 Marrie 3 Widowed 4 Divorced	d 1 1 Yes 2 □ 1	√o 1950-52	1 □Yes	-	Specify:	nican, etc./		ack, White, <i>ity:</i> Whi t	
21215-0036	72 hot natura fical E	Completed	15. Decedent's	Education	16a. I	Decedent's Us	ual Occupations	on on most of work	ina	16b. Kind of I	Business/Ir	ndustry
121	ithin 7	mple	Elementary/Secondary (0-12)	College (1-4or 5)+)			ing most of work	mg	_		
12	filed within Hygiene. other than "		12 17. Father's Name (First, Middle, La	net)		Metal La		8 Mother's Name	e (First, Middle, I		ruction	ı
Maryland	2 should be filed within n and Mental Hygiene. 'is marked other than "raumatic event, It e Me	o Be	Unknown O'Neill	101)					ie Healy	naidon odina		
aryl	shoul ind M i mark	2	19a. Informant's Name/Relationshi	(Type. Print)	19b.	Mailing Addres	s (Street and		al Route Number	; City or Tow	n, State, Zi	p Code)
	12 # C		Betty H. King/Comp	enion	5	904 Spaa	tz Plac	e, Rockvii	lle, MD 20	851		
ore	ges 1 and 2 should t of Health and Mer If item 27 is marke or other traumatic		20a. Method of Disposition 1 ☐ Burial 2 ☑ Commation	AD Removal from State	20b. Place of I cemetery	Disposition (Na ; crematory or	me of other place)	Aug	Date 4	20c. Location	n - City or T	own, State
E	Pag tment tant: I		4 □ Donation 5 □ Other (90e	cify)	Metropo	litan Cr	_	20	10	Alexand	dria, V	VA.
Beltimore,	permit. Pages t Department of H Important: If ite any Injury or ot once.		21. Signature of Fune al Service Li	cepsee		Franci 500 Un	nd Address s J. Co iversit	of Facility 11ins Fund y Blvd. W.	eral Home	Inc. Spring,	MD 209	901
			23a. Part 1 Enter the disease, or c shock, or heart failure. List or	omplications that caused	the death. Do no							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		e Coronary	Syndram	е					Onset and Death
	/Medical		resulting in death)	Due to (or as	a consequence of	f):						
	Examiner	J.,	Sequentially list conditions,	b	rsclerotic		isease					
	nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence of	r):						
,	execuna and ial-tra	Exar	that initiated events resulting in death) Last	c Due to (or as	a consequence of	f):					-	
68760,	ficate be executed physician and s the burial-transit	edical		d								
99	ng ph as th	Medi	IF FEMALE:									
Вох	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 Ectopic					ate of deliv	very Day Year
Ö	at the de by the a tached t	ysic	1 □Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	t time of death	5 ☐ Other (s	вресіту)					
٩.	that in the plant is detailed by		Part II. Other significant condition	s contributing to death b	ut not resulting in	the underlying	cause given	in Part I.	23e. Did to	bacco use co	ntribute to	the cause of death?
rds	v requires been sign should be	ed by							1 □ Y	es 2 🗆 No	3☐ Pro	obably 4 Unknown
Records,	e law requ has been e 2 should	Completed							24a. Was a		. Were aut	opsy findings available ompletion of cause of
<u> </u>	The l	Com							perform 1 □ Yes	med? 2 🖺 No	death? 1 ☐ Yes	
Vital	Physician: T this certificat ral director, pa	Be	25. Was case referred to medical examiner?	Hospital:			Othor		h (Check only or	•		
of		To	1 Yes 2 No 27. Manner of Death	1 ☐ Inpation	ent 2 ER/Out		OA	4 L Nursing Ho	ome 5 Residence 128d. Describe he			ify)
	Attending Phir death. ector: After thi by the funeral	tion	1 Natural 5 Pending 2 Accident investiga	(Month, Da	y, Year) In	jury M	28c. Injury a Work? 1 ☐ Ye	s 2 No	Edd. Boddilbo iii	on injury occi	arrou	
Division	r Attendi er death. rector: A by the fi	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	t be 28e. Place of Inj building, et	ury - At home, farr c. <i>(Specify)</i>	m, street, facto	ry, office		28f. Location (S City or Town		nber or Rui	ral Route Number,
Ö	ital or irs afte ral Dir led in	Cer								,		
	To the Hospital or Attene within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 ♣ Certifying (Check only one) 1 ♣ Certifying	Physician: To the best xaminer: On the basis of and manner st	f examination and	death occurre l/or investigation	d at the time n, in my opir	, date and place, nion, death occur	, and due to the or red at the time, o	cause(s) and late and place	manner as e, and due	stated. to the cause(s)
	To the I within 2 To the I сотрlet	Me	29b. Signature and title of certifier		()	25	c. License n	number	2	9d. Date sign	ned (Month	, Day, Year)
	10+1		Sugna	MI			014876			Jt	ıly 23	2010
	10		30. Name and address of person w Suresh Gupta, MD	ho completed cause of c			kville.	MD 20852				
	Sta		31. Date filed (Month, Day, Year)		ar's Signature			,				
	Registr	ar	AUG 04 20	10 Senson	P. 8	Man de an						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygierie Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** AŬĞÜST MOLLY JOSEPHINE COATES OWENS 2010 6:45 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner CHARLES COUNTY NURSING & REHABILITATION CENTER LA PLATA CHARLES If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. JUNE 17, 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year 1 ☐ M 2 T 213-74-6744 1923 MARYLAND 87 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show dical Examiner must be notified at 1 Yes 2 No Director MARYLAND CHARLES LA PLATA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 10200 LA PLATA ROAD 20646 UNITED STATES 238 death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 Yes 2 No Specify: Specify þ 3 Widowed 4 □ Divorced BLACK 'natural' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I've Ma mentary/Secondary (0-12) Coltege (1-4or 5+) 5TH GRADE HOMEMAKER PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) PHILLIP COATES OLIVIA JOHNSON COATES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a JULIAN P. COATES / SON 5529 MARLBORO PIKE, BOWIE, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ō 1 Burial 2 Cremation 3 Removal from State Department of Important: If eny injury or once. ST. MARY'S CHURCH CEMETERY AUGUST 7,2010 BRYANTOWN, MARYLAND 4 Donation 5 Other (Specify) 21. Signiture of Funeral Service Cicensia THORNTON FUNERAL HOME, P.A.
3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 LYDIA C. THORNION JOHNSON MO0583 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner DIYa Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last nsequence of) Examiner The law requires that the death certificate be executed burial-tran sician Physician/Medicai the use as 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Cher (specify) detached for o 9 Unknown 9 ☐ Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate 2 ANO 1 Tyes 2 □ No 1 Yes of Vital Attending Physician: ours after death.

Interest of the sertific filled in by the funeral director. Medical Certification: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4X Nursing Home 5 Residence 6 Other (Specify) 2**X** No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1- Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours after To the Funeral Dire 0

completely 1

State Registrar 29a. Certifier

MANISHA J. JARIWALA. 31. Date filed (Month, Day, Year) AUG 0 4 2010

30. Name and addre or rerson who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifing

11637 OLD WASHINGTON AVENUE, SUITE 103, WALDORF, MARYLAND M.D. 32. Pregistrar's Signature

Table 2 Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

AUGUST 3, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens For State Registrar 25913 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JUL 28 2010 Year AURORA GAMBOA ORTIZ 10:13 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 1 M 2 XX Months Days Hours Director 212-62-1628 77 05/917/11933 Philippines Usual Residence of Decedent or 28a-f shov notified at shov 10a. State 10b. County the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Virginia Fairfax Centreville 1 Yes XXXV 10e. Street and Number ō 10f. Zip Code "natural", or items 23a or edical Examiner must be 10g. Citizen of What Country? Funeral 15441 Eagle Tavern Lane 20120 USA 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2xXMarried þ 1 ☐ Yes 2 XXNo If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2x No Specify: 2 should be filed within remain and Mental Hygiene.
27 is marked other than "natural" 3 Widowed 4 Divorced Specify: Filipino Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) D.C. Government Cytotechnolohist 4 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Catalino Dytianquin Anhelina Gamboa permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic ones. traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorenzo M. Ortiz / Husband 15441 Eagle Tavern Ln, Centreville, VA 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2XXCremation 3 Removal from State Kalas Crematory or other t Edgewater, Maryland 4 Dongtion 5 Other (Specify) 8/5/2010 21. Signal of Funeral Service Lices 22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part 1. Enter the disease, or complications snock, or heart failure. List only one cause If t caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition ACUTE RESPIRATORY DISTRESS SYNDROME Medical resulting in death) Due to (or as a consequence of): Examiner Interstitial Lung Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Discase or impury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Dav Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Completed 1 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No Yes 2 X No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Yes 2 XNo 1 Alpatient 2 ER/Outpatient 3 DCA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending injury 1 Tes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier The individual control of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) B. 60 236490 (NY) MD July 29, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL

Registrar

State

LAURIE B.

31. Date filed (Month, Day, Year)
AUG 0 3 2010

LERNER

LCDR

MC

32. Registras's Sign

BETHESDA MD 20889-5600

USN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25914 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Timothy Daniel Perez July 31 2010 11:00 A M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 13501 Derry Glen Court, Apt 403 Montgomery Germantown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/27/1981 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours Min 1**X** M 2□ F 459-53-3868 29 Texas Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13501 Derry Glen Court, Apt. 403 20874 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 🕅 No Specify. Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accountant Accounting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pablo Perez Jr. Irene B. Salazar 19a. Informant's Name/Relationship (Type. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Domestic 13501 Derry Glen Court Germantown, Maryland 20874 Timothy Saunders Partner | 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 Removal from State August 4 ☐ Donation 5 ☐ Other (Specify) Peaceful Gardens Cem. 2010 Lubbock, Texas 21. Signature of Funeral Service Lice 22. Name and Address of Facility DeVol Funeral Home urtis 10 East Deer Park Drive Gaithersburg, 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hereditary Angioedema disease or condition resulting in death) Due to (or as a consequence of): HIV Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Substance Abuse Due to (or as a consequence of):

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

show

Director

Funeral

Completed

Be

၉

MD

ed other than "natural", or items 23a or 28a-f show event, the Weddeal Exercited at

with the Maryland

death

72 hours after

12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r

Pages 1 and 2 s ment of Health a Department of Health a Important: If Item 27 is any injury or other traconce.

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Z

13

a

Examine Physician/Medical þ Be Completed Certification: To

burial-tran attending physician for use as the buria signed by t I be detach page 2 this certific al director, after death

Director: /

Hospital or Attending n 24 hours after se Funeral Dire within 2 To the I the 2

Medical

29b. Signature and the of certifier

Huamin Henry Li,

AUG 04

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 5454 Wisconsin Ave.

62. Registrar's Signature

	d	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
		24a. Was an autopsy performed? 1 □ Yes 2 ☒ No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical examiner?	26. Place of Dea	th (Check only one)
examiner? 1∑ Yes 2 □ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing H	lome 5 X Residence 6 ☐ Other (Specify)
27. Manner of Death 1 X Natural 5 □ Pending 2 □ Accident investigation		28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 X Certifying P (Check only one) 2 Medical Exa	Physician: To the best of my knowledge, death occurred at the time, date and place miner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	e, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s)

29c. License number

D55098

Suite 700 Chevy Chase, MD 20815

29d. Date signed (Month, Day, Year)

August 3, 2010

Registrar DHMH 17 Rev 1/2001

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

			For State		State of M	aryland		artment of I <i>tificate of I</i>			-	_	e 201	n	25915
			Registrar 1. Decedent's Nam	e (First, Middle, La	st)			tineate or i	Jean	-	2. Date of De		10 <u>2</u> U 1	U	3. Time of Death
	Physicia Medic		John	Piontek							Month August		201	ear	1:30 a. M
	Examir				e street and number)			4b. City, Town, o	r Location	of Death	1	\neg	c. County of		11.00 4.
4				olls Par				I jam					Fred		
	Funeral Director		5. Social Security N 193–32–2	975	Sex IXM 2 □ F	e (In yrs. Ia 68	st birthday) Yrs.	If Under 1 Year Months Days	If Unde Hours	er 24 Hrs. Min.	8. Date of Bir (Month, Da 06/13	th <i>y, Year)</i> /19 2		Count	olace (State or Foreign try) sylvania
	nd how at	۲	Usual Residence of 10a. State	Decedent 10b. County		10c. City	, Town or Loc	cation						1	0d. Inside City Limits
	faryla 8a-f s tified	Director	MD	Freder	ick]	[jamsv	ille							1 🗆 Yes 2🌠 No
	the N	Ö	10e. Street and Nur				<u> </u>	10f. Zip Code				10g. C	Citizen of Wh	at Coun	try?
	n with	Funeral	3302 K	nolls Pa	rkway			217	54			1	United	. Sta	ates
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 ☐ Never Marr 3 ☐ Widowed	ied 2 🎇 Married 4 □ Divorced	12. Was Decedent I Armed Forces? 1 X Yes 2 If Yes, Give Year or Dates.		li d	Vas Decedent of H f Yes, specify Cuba D Yes 2 XNo	an, Mexica	an, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Black, Specify:	White, e	etc.
5-0	hour natul	olete	(Spe	15. Decedent's lacify only highest g			16a. Deced	lent's Usual Occup	ation	et of worki	ina.		Kind of Busin		lustry
2	hin 72 ne. than f	Completed	Elementary/Sec		College (1-4 or	i+)	life. Do	O NOT use retired)			ny	1	atelli		
2	ed within Hygiene. other tha	BeC	17. Father's Name (First Middle Last)	4		sate.	<u>llite en</u>			e (First, Middle,		ommuni	.cat:	Lons
au	should be file and Mental h is marked o raumatic eve	일	·	nk Piont							organi,		i Surname)		
ary	2 should be th and Men 27 is marke traumatic		19a. Informant's Na				19b. Mailin	ng Address (Street					or Town, Stat	e, Zip C	iode)
Σ	and 2 sl Health a tem 27 i		01ivia	Piontek	/ wife		330	2 Knolls	Park	way,	Ijamsv	i11	e, MD	217	54
ore	of Healt of Healt If item 2 or other		20a. Method of Disp		Removal from State			sition (Name of natory or other place	ce)	[Date	20c. l	Location - Ci	ty or To	wn, State
Ĕ.	Page 1 tment of tant: If it jury or o			5 Other (Spec			Olive	et Cemete	ery				ederic		
Baltimore,	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1		21. Signature of Fu	neral Service Licen	1	222		Name and Addre							
			23a. Part 1. Enter t shock, or hea	he disease, or con t failure. List only	plications that caused one cause on each line	the death	. Do not ente	er the mode of dyin	ıg, such a	s cardiac o	r respiratory ar	rest,			Approximate Interval Between
- 4	nysician/	- 15	Immediate Cause (disease or condition		ex ma	TRO	9410	- LAT	ERA	~ 5	ueno	انک د	5		Onset and Death
	Medical Examiner		resulting in death)	•	Due to (or as	a conseque	ence of):								
		ē	Sequentially list co	nditions,	b. Due to for as	a constant	ence off:							-	
L	ted 1 Insit	Examine	cause. Enter Under Cause (Disease or	rlying iinjury											
P	execu an and ial-tra	EX	that initiated events resulting in death) I	_ast	Due to (or as	a conseque	ence of):								
200	cate be executed physician and s the burial-transit	edical			d									\perp	
687	rtifica ling pl e as tl	/Me	IF FEMALE:		00- 16	-f									
Box	hat the death certific ed by the attending detached for use as	Physician/M	23b. Was decedent in the past 12 r 1 Pes 2 Duknown	months?	23c. If yes, outcome 1 Live Birth 4 Pregnant a g Unknown	2 🗌 Fetal	death 3	Ectopic pregnand Other (specify)	ру ————————————————————————————————————			Ì	23d. Date of Month		ry Day Year
Division of Vital Records, P.O.	Physician: The law requires that the this certificate has been signed by the rall director, page 2 should be detach	by Ph	Part II. Other signif	icant conditions	ontributing to death b	ut not resu	Iting in the ur	nderlying cause gi	ven in Par	t I.	23e. Did to	bacco	use contribu	te to the	e cause of death?
JS,	w requires that seen signed to should be detailed	ed b							-		1 🗆	Yes 2	2 □ No 3	☐ Prob	ably 4 Unknown
Ö	law req has bee je 2 sho	Completed									24a. Was		24b. Wer	e autop	sy findings available
Rec	ysician: The la is certificate ha director, page	Som										rmed?_	dea	th?	2 No
ta	sician: The certificate rector, pag	Be	25. Was case referre examiner?		Hospital:					ath (Check	only one)	(3)		den mo	
Ę.	Physi this c	<u>ان</u>	1 Yes 2 2	₹No	1 Inpati		R/Outpatien 28b. Time of	t 3 DOA Oth	4 ⊔ N		me 5 Resid			Specify)	
0 0	nding ith. After fune	cate	1 Natural 2 Accident	5 Pending Investigatio	(Month, Day	, Year)	injury	work			28d. Describe h	ow inju	ry occurred		
isio	Atter er dea ector by the	Certificate:	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Inju		ne, farm, stre	et, factory, office			28f. Location (S	treet ar	nd Number o	r Rural i	Route Number,
Ξ	ital or irs afta ral Dir led in				building, etc	. (Specify)	_				City or Tow	n, State	9)		
	To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: After this completed filled in by the funeral di	Medical		Medical Exam	sician: To the best of iner: On the basis of e se Practioner: To the	xamination	and/or investi	igation, in my opinio	on, death o	occurred at	the time, date a	nd place	e, and due to	the cau	se(s) and manner stated.
	Vith Con	_	29b. Signature and		0) .	C 1 . 1	29c. License		,		29d. Da	ate signed (N	fonth, D	ay, Year)
			10	ひん (low for	7 M	12 M	ar ro	50	60		Au	JUST	10	2010
	1041				completed cause of d						\m	0-	-0		
	Stat	e	Laura C 31. Date filed (Mont)	lawson C	32. Registra	IN . Ca ır's ≜ ignatu	rolin	e St., Ba	<u>altin</u>	nore,	MD 212	8/			
	Registra	ar	31. Date filed (Mont)	8 2010	32. Registra	B. A	parks								

			For State Registrar	State	of Mary	land / Depa	artment <i>tificate</i>			and M	lental Hy			10	259	16
			Decedent's Name (First, Michael Control of the	ldle, Last)			imouto	<u> </u>	outri		2. Date of De	Reg. No.			3. Time of D	
and a	Physicia Medic	cal	ELEANOR DUANE								07/22/	/2010	/	Year	1331	М
	Examir	ner	4a. Facility Name (if not institute Holy Cross Hos		number)		4b. City, To Silv∈						County		-	
	Funeral		5. Social Security Number	6. Sex	7. Age (In)	yrs. last birthday)	If Under 1	Year		,	8. Date of Bir	rth	T	omer 9. Birtho	ace (State or I	Foreign
	Director		214-28-9998	1 □ M 2 🔀	F 81	Yrs.	Months I	Days	Hours	Min.	05/25/	1929		Count	MD	or orgin
	nd now	١	Usual Residence of Decedent 10a. State 10b. Cour	nty	100	. City, Town or Lo	cation							14	ad Janeida Oit	Line
	arylar ta-f s	ectc	MD Monto	omery		ilver Sp] "	d. Inside City	
	or 28	ä	10e. Street and Number	CHELY		TIVEL DE	10f. Zip C	ode				10g. Citi	zen of W	hat Count		
	s 23a rust b	Funeral Director	632 Sligo Aver	nue			209	10				USA			•	
	death item ner m		11. Marital Status	12. Was D	ecedent Ever in		Vas Deceden Yes, specify	t of His	panic Orig	in? (Spec	cify Yes or No-			- America		
36	after al", or xami	d by	1 Never Married 2 No No No No No No No No No No No No No	If Yes,			☐ Yes 2X				,,		віаск Specify:	, White, e		
9	hours natura ical E	lete		ed Year or dent's Education	Dates.	16a, Deced	lent's Usual C)ccupat	tion		-			Blac		
215	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed by	(Specify only high	hest grade complet	ed) e (1-4 or 5+)	(Give I	aind of work of NOT use re	done du		of workin	g	10b. Kii	iig of Bus	siness inu	ustry	
21	d with ygien her th	Be C	12th			Domes	tic					Hom	e			
Maryland 21215-0036	be filed ental Hy ked oth c event	To B	17. Father's Name (First, Middle Garfield Dorse					- 1			(First, Middle,		Sumame)			
Ž	should be hand Ment 7 is marked traumatic e	ľ	19a. Informant's Name/Relatio			10. 14.75		_			ustus					_
Σ	12 shallth ar 27 is r trau		Eleanor Denise		- dau	ghter 6	g Address (S 32 Sli	treet an	a Number Avenu	or Hurai 1e . S	Route Numbe	er, City or Spri	rown, Sta na	ate, Zip Ci MD 20	ode))9 10	
Jre,	1 and of Hea f item		20a. Method of Disposition		20	Db. Place of Dispo	sition (Name	of			ate			City or Tov		
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 🕅 Burial 2 🗌 Cremation 4 🗆 Donation 5 🗆 Othe	on 3 ∐ Removal fro (Specify)	om State	D Nat/1				3/4/1	-0	Lau	rel,	MD		
3alt	permit. Departr Importa any inju		21. Signature of Funeral Service	e Licensee	An	22	. Name and A	Address	of Facility	Sno	wden F	uner	al H	ome		
	70 = 60	_	000000	go /x	× -						t, Roc		le, l	MD 20	0850	
			23a. Part 1. Enter the disease, shock, or heart failure. Lis Immediate Cause (Final	only one ause on	each line.		r the mode o	f dying,	such as c	ardiac or	respiratory ar	rest,			Approximate Interval Betwe Onset and Dea	
	Pnysician/ Medical		disease or condition resulting in death)	a.	to (or as a cons										Onset and Dea	atri
	Examiner				pertns.											
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter U. danying Cause (Disease or iinjury	b. —	to (or as a cons									/		
	cuted	xam	that initiated events	c												
	ate be executed obysician and the burial-transit	dical Examiner	resulting in death) Last	Due	to (or as a cons	sequence of):										
760	cate be ex physician s the buria			d												
Box 687	eath certifica attending p	by Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o	outcome of pre	gnancy							3d Date	of deliver	v	
Š	death e atte	sicia	in the past 12 months? 1 Yes 2 No	1	egnant at time	Fetal death 3 Cof death 5 C	Ectopic pred Other (speci	nancy fy)					Mont		ay Yea	r
o.	requires that the de been signed by the should be detached	Phys	9 Unknown								_					
σ.	es tha	by	Part II. Other significant condi	tions contributing to	death but not	resulting in the ur	nderlying cau	se giver	n in Part I.						cause of deat	
<u>10</u>	requir	etec	PSCINC		_										bly 4 □XUni	
eco	e law e has t ge 2 s	Completed				1					24a. Was autop	an osy rmed?	pri	ere autops or to com ath?	y findings ava pletion of caus	ilable se of
m m	Physician: The lav	o C	25. Was case referred to medical	al I	-			6 Plac	e of Death	(Chaok	1 Tyes	2X No	1 [Yes 2	№ No	
Zite	ysicia is cert direct	To Be	examiner? 1 ☐ Yes 2 🎇 No	Hospital:	☐ Inpatient 2	XER/Outpatien		Other:			ne 5 🗆 Resid	lanca 6	Other	(Spaciful		
o	ding Ph th. After th funeral	rte:	27. Manner of Death 1 Natural 5 Pend	28a. Da	te of injury onth, Day, Year	28b. Time of	28c.	Injury a work?			d. Describe h					
io	ttendii death. tor: Ai the fu	Certificate:		stigation			М	1 🗆 Ye	es 2 🗆 N	10						
Division of Vital Records, P.O.	the Hospital or Attending Physician: The law requires that the death certifich in 24 hours after death. the Funeral Director: After this certificate has been signed by the attending properted filled in by the funeral director, page 2 should be detached for use as	Cert		mined 28e. Pla	ce of Injury - A Iding, etc. <i>(</i> Spe	t home, farm, stre ec <i>ify)</i>	et, factory, of	fice		28	Bf. Location (S City or Tow		Number	or Rural R	oute Number,	
Ω	spital	edical	29a. Certifier 1 X Certifyi	ng Phy sician: To the	best of my kn	owledge, death o	ccured at the	time. d	ate and pla	ace, and	due to the car	ise(s) and	manner	as stated		- 10
	To the Hospital or J within 24 hours after To the Funeral Dire completed filled in b	Med	(Check 2 ☐ Medica	Examiner: On the b	asis of examina	ation and/or investi	gation, in my	noinian.	death occi	irred at th	ne time date a	nd place a	and due to	n the cause	e(s) and manne ed.	er stated.
_	To t To til	_	29b. Signature and the of certif				29c. Lid					29d. Date				
	3	ļ	Kvou	7 7	Mar	φ		669.	l			7,	/23/	LO		
			30. Name and address of perso	~ 7.77.07	TTo see to	Donale (75 2007 0	C	:]=====	C	Jan. 35	D 201	200			
	Stat	e_	Ghousia Sultan 31. Date filed (Month, Day, Year)	a 1210/	Registrar's Sig	ge Park	TLCT6	, S.	river	spr	ing, M	ע 205	JU6			
	Registra		AUG 02	2010 Den	me 1	3. park										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 | 0 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ July 20 Day Annette Poindexter 2010 9:10A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Esmond <u>Germantown</u> If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. \$7.85 88 N 505 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 10/26/1970 Birthplace (State or Foreign Country)
 DC Funeral 1 □ M 2 🕇 F Director 39 Usual Residence of Decedent or 28a-f show 10a. State 10h County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director Germantown 1X Yes 2 No MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20874 USA 15 Esmond Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. "natural", or 1 X Never Married 2 Married Completed by 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) NIH Elementary/Seconday (0-12) College (1-4 or 5+) Housekeeper Federal Govt. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Jeanette Harley <u> Aubrev Poindexter</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirnette E. Poindexter permit. Page 1 and 2 st Department of Health a Important: If item 27 is 12444 Quail Woods Dr. Germantown, MD 20874 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) <u>Heritage Memorial</u> 7/31/10 Waldorf, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Latney's Funeral Home, Inc. B831 Georgia Ave. NW Washington, DC 20011 cc0278 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Metastatic Carcinoma of Breast Approximate Interval Between Onset and Death Immediate Cause (Final dysician. to Lung, Brain, Bone
Due to (or as a consequence of): disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin burial-transit that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes No Dav Year Pregnant at time of death Unknown 1 Yes 24 ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? page certificate 2 🗆 No Yes 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 **X**No Other: 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5x Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred the Hospital or Attending Natural 5 Pending within 24 hours after death. To the Funeral Director: A 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) npleted filled in by determined Medical 🔯 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

State

allest

H 31. Date filed (Month, Day, Year)

Robert

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore, Maryland 21215-0036

Box 68760

Records,

Division of Vital

1500 Forest

29c. License number

Md D0055522

Glen Rd. Silver Spring, MD

July 21,2010

State of Maryland / Department of Health and Mental Hygiens 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Year July 29, 2010 6:00 p M Ruby Peacock /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kensington Park Retirement Community Kensington If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Nov. 9, 1916 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 ️ F Months Days Hours Yrs 459-14-7234 Texas 93 Director Usual Residence of Decedent death with the Maryland 10a. State 10h County 10c. City, Town or Location th and Mental Hygiene. 27 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Exychat must be notified at 10d. Inside City Limits Director Yes 2 No Texas Gregg Kilgore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 804 Parkview Lane USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☐Yes 2 🕱 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐Yes 2K No Specify. ģ Specify: White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Retail Clothing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Volley Bruce Grimsley Liddie Ann Hughs ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 Is any injury or other trauonce. Eltanette Proctor/Daughter 3620 Littledale Road, Kensington, MD 20895 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State July 30, 2010 Burial 2 ☐ Cremation 3 ☐ Removal from State Overtan Cemetery Overton, Texas 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) a. Motastatic Ovarian Carcinova /Medical Due to (or as a consequence of): Examiner b Diabetes Mellitus, Type II Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of: Hospital or Attending Physician: The law requires that the death certificate be executed Ascites and burial-tran Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical Atherosclerotic Heart Disease IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 ☐ Other (specify) P.O. the detached 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. \$ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has perform certificate 2 ∐No 1 ☐ Yes 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4^{*} Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation aspital c.
4 hours after dea.....rai Director: After 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 124 hours a To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Underlicated Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) To the I within 2 To the I 29b. Signature and title of cer 29c. License number 29d. Date signed (Month, Day, Year) D53691 July 30, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ajay Reddy, MD 3299 Tower Oaks Blvd., #110, Rockville, MD 20852 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 02 2010 Registrar

			For State	State of M	larylan		artment of F				010	25919
			Registrar 1. Decedent's Name (First, Middle, La	ast)		Cer	uncate of L	Jean	2. Date of Dea		010	3. Time of Death
	Physicia		JOHNNY OTIS PAYNE						07/28/2		Year	12:34 PM
	Medic Examir		4a. Facility Name (if not institution, given				4b. City, Town, or	r Location of Deatl			County of Death	
	1		Holy Cross Hospit	al			Silver 3	An		Mo	ntgomer	y
	Funeral Director			1 XM 2 F	je (In yrs. la 51	st <i>birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 07/20/	1949	9. Birth Cou	place (State or Foreign ntry)
	d tow	L	Usual Residence of Decedent 10a, State 10b, County		10c City	, Town or Loc	cation					10d. Inside City Limits
	Marylar 28a-fsk otified	Funeral Director	MD Montgon	mery		kville	Janon					1 🗆 Yes 2 🗖 No
	th the 3a or t be n	a D	10e. Street and Number				10f. Zip Code			-	en of What Cou	intry?
	ath wir ms 2 musi	ner	4311 Merton Road	12 Mas Decedent	Function III C	- I40 V	20853	ii- Orioi-2 (C-		USA		
36	1 and 2 should be filed within 72 hours after death with the Maryland if Heatth and Mental Hygiene. tiem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	Marital Status Never Married 2 ☐ Married Widowed 4 ☐ Divorced	If Yes, Give	No 196 197	69-	Vas Decedent of H f Yes, specify Cuba ☐ Yes 2 XNo		o Rican, etc.)		4. Race - Ameri Black, White, pecify: Bla	etc.
21215-0036	hours natura lical E	Completed	15. Decedent's		19	16a. Deced	lent's Usual Occup		- 1	16b, Kin	d of Business Ir	
218	in 72 e. han "i	E I	(Specify only highest of Elementary/Seconday (0-12)	grade completed) College (1-4 or	5+)	(Give I life, DC	ind of work done of NOT use retired)	during most of wor	king			•
	d with lygier ther ti nt, th	BeC	12th			Consu	<u>ltant</u>					of Energy
Maryland	oe filed intal Hy ced oth	다 B	17. Father's Name (First, Middle, Last, Johnnie Lee Payne						me (First, Middle, I an Tillma		urname)	
Ž	should be file and Mental F is marked o raumatic eve	Ė	19a. Informant's Name/Relationship			10h Mailin	g Address (Street a				own State Zin	Codel
	and 2 sh Health ar tem 27 is		Johnita Porter -			7620	Dover Dri	ive, Ypsi		/II 48	197	<u> </u>
Baltimore,	per it. Page 1 a Der artment of H Important: If ite any injury or ot		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	' I	/	sition (Name of natory or other plac	i	Date		ation - City or T	
Ē	pernit. Page 1 Der artment of Important: If i any injury or once.		4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Lice		Gabe	7	eaven . Name and Addres	8/3/	<u>'10 </u>		<u>er Spri</u>	
m	Der arr Impor any in		Denge	1 Ame	ch	\ /	46 N. Was					
			23 Part 1. Enter the disea , or cor shock, or heart failure. List only	nplications that cause o cause on each lin	d the deat	1		_				Approximate Interval Between
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	_ a			y failure	9				Onset and Death
	Examiner			Due to (or as ARDS		,	iratory d	distress	syndrome	≘)		
	- ±	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as		•				•		
	ecuter and I-trans	Exan	Cause (Disease or iinjury that initiated events resulting in death) Last	c			nd sepsis	3				
0	e be ex ysician e buria	ical		■ d	·	,	_					
876	tificate ng phy as th	Med	IF FEMALE:									
Box 68760	Attending Physician: The law requires that the death certificate be executed ar death. The death. Extor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 - Fetal	Ideath 3 🗌	Ectopic pregnand Other (specify)	ру 		23	3d. Date of deliv	very Day Year
P.O.	es that the dea signed by the a be detached f		Part II. Other significant conditions	contributing to death b	out not resu	ulting in the u	nderlying cause giv	ven in Part I.	23e. Did to	bacco use	e contribute to t	he cause of death?
Is, F	uires ti n signi Ild be	ed by							1 □ Y	∕es 2 □	No 3 □ Pro	bably 4X Unknown
cord	: The law requires cate has been sig page 2 should b	Completed							24a. Was a		24b. Were auto	ppsy findings available ompletion of cause of
Re	The la	lo S							perfor 1 Yes	med? 2 🖾 No	death?	2 🗆 No
ta	ysician: The is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:			26. Pl	ace of Death (Che				
γV	Phys	 10	1 Yes 2 No 27. Manner of Death	1 X Inpati 28a. Date of inju		ER/Outpatien 28b. Time of	t 3 DOA 28c. Injury	4 ☐ Nursing F	ome 5 Reside			y)
o uc	nding ath. r: After e fune	icate	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Da	y, Year)	i nj ury	work	Yes 2 No	Zod. Describe no	ow injury c	occurred	
Division of Vital Records,	al or Atte s after des I Directo d in by th	Certificate:	3 Suicide 6 Could not 4 Homicide determined				et, factory, office		28f. Location (St City or Town		Number or Rura	l Route Number,
_	To the Hospital or Attending Phys Within 24 hours after death. To the Funeral Director, After this Completed filled in by the funeral di	Medical	(Check 2 Medical Exar	ysician: To the best of niner: On the basis of e rse Practioner: To the	xamination	and/or invest	igation, in my opinio	on, death occurred	at the time, date an	nd place, a	and due to the ca	use(s) and manner stated.
	North Com		29b. Signature and title of certifier				29c. License		2	29d. Date	signed (Month,	
	20		MON	~				3639		07	28	2010
			30. Name and address of person who Pothu Nagabhyrn	completed cause of c				er Sprinc	. MD 209	910		
	Sta	te	31. Date filed (Month, Day, Year)	32 Registra			Ked .		,,			

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene 25920 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2010 Pear Month 07 Bradley Joseph Proffitt 26 12:01 aM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3709 37th Avenue Prince Georges Cottage City 5. Social Security Number 6. Sex 1 M 2 D F If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Hours 08 18 18 y, ^{Year} 953 212-64-7844 Director 56 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director ems 23a or 28a-f sh r must be notified ह 1 x Yes 2 □ No MDPrince Georges Cottage City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3709 37th Avenue 20722 USA 12. Was Decedent Ever in U.S. Armed Forces? HD Yes 2 □ No If Yes, Give 2/77-3/79 Year or Dates2/77-3/79 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ō ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White "natural", Completed 3 Widowed 4 Divorced traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Systems Engineer Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Harold Lloyd Proffitt Eileen Cecelia Robins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Donna Leigh Proffitt / Wife 3709 37th Avenue Cottage City, MD 20722 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o 1 🗆 Burial 2XX Cremation 3 🗀 Removal from State Lincoln Crematory 08/02/2010 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) of unival Service in see 22. Name and Address of FacilityFt. Lincoln Funeral Home 3401 Bladensburg Rd. Brentwood, MD 20722 23a. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause or each line. Immediate Cause (Final Onset and Death monory Eurholesu Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consultance of ng physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown signed by 23e. Did tobacco use contribute to the cause of death? ξ Vellaces Throusous 1 Yes 2 No 3 Probably 4 Unknown Completed Peripheral Edeura 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has Chronical wohol abuse performed? Yes 2 N 2 🗆 No Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Funeral Director: After sted filled in by the funer 1 Natural 5 Pending 24 hours after death. 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basic of examinating and/or inventioning in a stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

Registrar

31. Date filed (Month, Day AUG 0 3 115 Centerce on Trechet HID 2000

av-18/ Yearste To

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

anote, our

State of Maryland / Department of Health and Mental Hygiene | | 25921 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2010 Year July 23, 5:20 Рм ROBERT JUNIOUS PAIGE SR /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Village Health Care Center Gaithersburg Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace Country)
August 4, 1925 Weldon, Birthplace (State or Foreign Country) **Funeral** Months Days Hours 110 M 2□ F 84 241-30-7451 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 7 is marked other then "naturel", or items 23a or 28e-f show treumetic event, the Madical Extentrier must be notified at TX Yes 2 No Directo MD Montgomery Germantown 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 11445 Herefordshire Way 20876 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1969 Year or Dates: 1969 Specify: Black 1 Yes 2K No Specify: \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry it. Pages 1 and 2 should be filed within 72 k intment of Health and Mental Hygiene. intent: If item 27 is marked other then "nat 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) United States Air Force Master Sergeant years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Julius Paige Mary E. Whitehead 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert J. Paige, Jr. - Son 11445 Herefordshire Way, Germantown, MD 20876 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State injury or 08-26-2010 * 4 □ Donation 5 □ Other (Specify) Arlington National Arlington, Virginia permit.
Departr
Importe 22. Name and Address of Facility Johnson & Jenkins Funeral Home 21. Signature of Funeral Service cieensee 716 Kennedy Street, NW, Washington, DC 20011 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a, Part1. Enter the disease. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CORONARY ARTERY DISEASE /Medical Due to (or as a consequence of): Examiner HEMORRHAGIC CYSTITIS Sequentially list conditions, if any, loading to manufact cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit CLOSTRIDIUM DIFFICILE COLITIS Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical DYSPHAGIA as the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ĺ in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐ Yes 2☐ No be detached the 9 Unknown 9 Unknown ģ Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 Yes 2₺ No 1 ☐ Yes 2 No or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending 1 57 Natural death. investigation 1 🗌 Yes 2 No 2 Accident within 24 hours after death To the Funerel Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospitel 29a. Certifier 🔁 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D41162 July 27, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10+1 Vinu Ganti, MD, 19529 Doctors Drive, Germantown, Maryland 20874 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 0 3 2010 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 25922 Reg. NZ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death AUG" 6,2010 Year **Physician** 9:25P GERALD DAVID ROBERTS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CHARLES WALDORF 11571 TERRACE DRIVE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 6 Menth, Pay Sear 9. Birthplace (State or Foreign MD ountry) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral ™** M 2□ F Months Days Hours Min. 58 214-58-4577 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f show ther traumatic event, It a Medical Evertings must be notified at 10a. State 10b. County 10d. Inside City Limits CHARLES WALDORF MD. 1 ☐ Yes 2 🙀 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code U.S.A. 11571 TERRACE DRIVE 20602 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 ☐ Xlo Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) FABRICATOR R&R FABRICATION 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be VIOLET DUKE LESTER ROBERTS ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DIANE ROBERTS-SPOUSE 11571 TERRACE DR. WALDORF, MD. 20602 permit. Pages 1 and 2 Department of Health Important: If item 27 any Injury or other tr once. Method of Disposition

1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State R

1 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

INITY MEM • GARDENS Date 20c. Location - City or Town, State 20a. Method of Disposition 8-12-10 WALDORF, MD. 4 ☐ Donation 5 ☐ Other (Specify) M00479 Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A.
LA PLATA, MARYLAND 20646 21. Signature of Fuperal Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final l Sclesof Amyota **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, aftending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No certificate has been signed by the irector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy 1 ☐ Yes 2 No within 24 hours after death,

To the Funeral Director: After this certific,
completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Besidence 6 Other (Specify) 1 Yes 2₽No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 0 32. Regisear's S State Registrar

		1 - State State Registrar	of Maryland / Depa <i>Cer</i>	artment of F rtificate of L	Health and I Death			0 25923
		Decedent's Name (First, Middle, Last)		imouto o. 2	20011	2. Date of Death		3. Time of Death
Physicia Medio		Jeong Sun Ruppel				July 31	Day 2010 Yea	
Examin	er	4a. Facility Name (if not institution, give street and nur	nber)		or Location of Death	1	4c. County of D	
Funeral		304 Fairgrove Terrace 5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year		8. Date of Birth	Mont go	Birthplace (State or Foreign
Director		578-88-4924 1 □ M 2 X F	57 Yrs.	Months Days	Hours Min,	04/13/1	953 Sc	Country) Outh Korea
how at	ř	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	cation				10d. Inside City Limits
farylar Ba-fsl tified	Director	Maryland Montgomery	Gaithe					1 ☐ Yes 2 X No
the M a or 28 be no	j	10e. Street and Number	0020110	10f. Zip Code		11	0g. Citizen of What	. Country?
h with ns 23a must l	Funeral	304 Fairgrove Terrace		208			United S	States
r deatl	by Fu	Armed Fo	edent Ever in U.S. 13. Vorces? 13. Vorces?	Nas Decedent of H f Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race - A Black, W	merican Indian, /hite, etc.
Z15-UU36 in 72 hours after e. nan "natural", o Medical Exam	ed b	3 Widowed 4 □ Divorced If Yes, Giv Year or D	ve 1	1 ☐ Yes 2 🗶No	Specify:		Specify: A	Asian
2 hour	Completed	15. Decedent's Education (Specify only highest grade completed	(Give I	dent's Usual Occup kind of work done o	during most of work	kina	16b. Kind of Busine	ess Industry
ithin 7 ene. r than	Com	Elementary/Seconday (0-12) College (1	1-4 or 5+) life. DO	O NOT use retired)			Dry Cle	eaner Company
illed will Hygi	B	17. Father's Name (First, Middle, Last)	Fian	ager	18. Mother's Nam	ne (First, Middle, M		aller Company
Vian d be f Menta arked aric e	은	Soung Duk Kim			Choung	Suk Cho	ung	
Maryland 2 should be filed th and Mental H; 77 is marked oth traumatic even		19a. Informant's Name/Relationship (Type, Print)	1.4				City or Town, State,	
and 2 Health Health tem 2;		Nadia Saadipour (Daught 20a. Method of Disposition	20b. Place of Dispos				rsburg, M	Maryland 20877
battimore, Maryland 21213-0036 Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)		natory or other plac	ce) ¦ Angu	st 03	•	
Baltimor Fermit. Page 1 Department of Important: If if any injury or o		21. Signature of Funeral Service Licensee			ss of Facility De	Vol Fune:	Alexandii ral Home	la, Virginia
		May Jothan	M00689 1	0 East De	eer Park	Drive Ga	ithersbur	g, MD. 20877
		23a. Part L. Enter the disease, or complications that shoot, or heart failure. List only one cause on ea	caused the death. Do not ente ach line.	er the mode of dyin	ig, such as cardiac	or respiratory arres	it,	Approximate Interval Between
Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	AS HD					Onset and Death
Examiner		Due to	(or as a consequence of):					
	iner	Sequentially list conditions, if any, leading to immediate Due to cause. Enter Underlying	(or as a consequence of):					
cuted	xam	that initiated events c						
r ou cate be executed physician and the burial-transit	edical Examiner	resulting in death) Last Due to	(or as a consequence of):					
icate by physics the b		d						
DIVISION OF VITAL RECORDS, F.O. BOX 9017 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Physician/M	Lob. Was according program.	tcome of pregnancy Birth 2 Fetal death 3	1 ⊑ctonic pregnanc	01/		23d. Date of	delivery
DOX death c the atten	/sici		gnant at time of death 5	Other (specify)	-y		Month	Day Year
at the		Part II. Other significant conditions contributing to d	leath but not resulting in the u	nderlying cause giv	ven in Part I.	23e. Did toba	acco use contribute	e to the cause of death?
J. Initial of the state of the	od by					1 ☐ Yes	s 2 □ No 3 □	Probably 4 Unknown
w requ	plete					24a. Was an		autopsy findings available
Physician: The law requires tritis certificate has been signal director, page 2 should be	Completed					autopsy perform	prior to death	to completion of cause of 1? Yes 2 □ No
ysician: 7	Be	25. Was case referred to medical examiner?			lace of Death (Chec		(2.10)	100 1 2
g Physic er this c	2	1 Series 2 □ No Hospital: 1 □ 27. Manner of Death 28a. Date	Inpatient 2 ER/Outpatien of injury 28b. Time of		4 L Nursing Ho	ome 5 Resider 28d. Describe how	nce 6 Other (Sp	pecify)
ading th. :: After e fune	Certificate		oth figury (1997) injury	work	yat ⟨? Yes 2 □ No	28d. Describe nov	/ injury occurred	
r Attendir ter death. irector: Af	ertifi 	3 Suicide 6 Could not be 28e. Place	e of Injury - At home, farm, stre ing, etc. (Specify)					Rural Route Number,
ital or ral Dir.						City or Town,		, j
Hosp 24 hou Fune eted fi	Medical	29a. Certifier 1 Certifying Physician: To the base (Check 2 Medical Examiner: On the base)	sis of examination and/or investi	igation, in my opinio	on, death occurred a	it the time, date and	place, and due to th	ne cause(s) and manner stated.
Fo the vithin Fo the somple		only one) 3 ☐ Certifying Nurse Practioner: 29b. Signature and title of certifier	To the best of my knowledge, a	death occurred at the 29c. License			ause(s) and manner d. Date signed (Mo	
5		Inthe pms		m 3	20018		5/2/10	
		30. Name and address of person who completed caus		rint)	2			
		Betsy Ballard, M.D., 21			, #304, S	Silver SP	ring, MD	20902
Stat Registra	e r	31. Date filed (Month, Day, Year) AUG 04 2010	Registrar's Signature	Red.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For
State
Registrar 25924 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death $11:00 P_M$ Physician/ Year Jump 31, P2010 Bernard H. Ross , Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Suburban Hospital Bethesda Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1**X** M 2 □ F Days Hours Min. 05/29/15/34 New York 072-26-2289 76 Yrs Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits or other traumatic event, the Medical Examiner must be notified at Director Montgomery MD Bethesda 1 X Yes 2 No 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 20814 Funeral 5450 Whitley Park Terrace, #202 items 23a 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 5 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give 1955 Completed by Maryland 21215-0036 White 1 ☐ Yes 2 No Specify. "natural", Specify: 3 Widowed 4 Divorced 1957 Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event the Mananary injury or other traumatic event the Mananary Elementary/Seconday (0-12) College (1-4 or 5+) Education 5+ Professor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Nettie Friedman Leonard Ross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number City or 5450 Whitley Park Terrace, #202 Marlene Ross-Wife 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other placel Garden of Remembrance 08/03/2010 Clarksburg, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Edward Sagel Funeral Direction Inc. 1091 Rockville, MD 20852 21. Signature of Fun M01163 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) memoral Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or finjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the burnels. Division of Vital Records, P.O. Box 68760 IF FEMALE: Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Month Year Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> listage ad Gusows 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? erelwovasculur 24a. Was an autopsy performed 2 🗆 No Yes 2 No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital ၉ Other: 1-Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending 1 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Descriping Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Descripting Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tit 29c. License numbe 29d. Date signed (Month, Day, Year) 20061302 10 id

Registrar
DHMH 17 Rev 7/2009

State

8600 Old Georgetown Road

Bethesda, MD 20814

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Atul Rohatgi,

AUG

04

31. Date filed (Month, Day, Year)

10-05756 Plea Felipe Martinez Rodriguez

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene

e 2	0	000000000000000000000000000000000000000	0	2	5	9	2	
_	-							

		1- For State Registrar	Cert	fificate of L	Death	,,,	Reg. N	No.	
Physicia Medical Exami	an/	1. Decedent's Name (First, Middl Felipe	_{e,Last)} Martinez	Rodri	guez		Date of Death Month Da July 31, 2010	ay Year)	3. Time of Death 1340 hrs
¥		4a. Facility Name (if not institution Prince George's Hosp	ital Center		. City, Town, or Loca Cheverly			4c. County of Dea	ge's
Funeral Director		5. Social Security Number none	6. Sex 7. Age (In yrs. las	st birthday) Yrs.		f Under 24Hrs. 8 Hours Min.	Date of Birth (M 2/24/1	980 For	Birthplace (State or Bign CoMeXICO
15-0036 filed within 72 hours after death with the Maryland Hyggene. ed other than "natural", or items 23a or 28a-f show any i, the Medical Examiner must be notified at once.	Funeral Director	10e. Street and Number 5607 Nichols 11. Marital Status 1 Never Married 2 Marital	ce George's son Street #202 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 X No). 13. Was I	lale Par Of. Zip Code 20737 Decedent of Hispani, specify Cuban, Me	ic Origin? (Speci exican, Puerto Ric	fy Yes or No-	White, etc. พีไก	10d. Inside City Limits 1 X Yes 2 No untry? erican Indian, Black,
nore, MD 21215-0036 ages I and 2 should be filed within 72 hours after nt of Health and Mental Pygiene. it: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner.	Completed by	15. Decedent's Education (Spec Elementary/Secondary (0-12)	College (1-4 or 5+)	during mos	Usual Occupation (t of working life. DO ruction	Give kind of work NOT use retired WORKE	done 16i	Specify: D. Kind of Busines Constru	31.7
21215-003 uld be filed withi Mental Hygiene, marked other ti c event, the Med	Be	17. Father's Name (First, Middle, German Marti	nez Roblez	Lach Mailing	V		a Rodri	guez Va	
MD 21 and 2 should saith and Mer em 27 is man	٦٩	Cristino Mar 20a. Method of Disposition	hip (Type, PrinBrother/ tinez Rodrigue	z 560	ddress (Street and 7 Nicho on (Name of cemete	lson St	#202	Riverda	ale Park, Mc
		1 XBurial 2 Cremation 4 Donation 5 Other Sp	3 X Removal from State Cem Mun Fra	meterie icipal ncisco	e de San Guichi	nal		Yautepec Oaxaca	
1 0 8 0 E		21. Signature of Funeral Service	Complications that caused the death. I	1924	I COLUM	pia RT/	7a.Siiv	er Spri	ICE, P.A. ing, Md2091
Physician /Medical Examiner		failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line.	i	mode of dying, ode		opinatory arrost, t		Between Onset and Death
	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b. Due to (or as a consequence of): c.						
executed ian and ial - transit	al Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):	·					
760, cate be physical	/Medical	UNPENDED IF FEMALE: 23b Was decedent pregnant in th	#8,200,c_perFH8	8-9-10,E				23d. Date of delive	•
Box 68 death certif he attending d for use as	Physician	past 12 months?	4 Pregnant at time of deat	th ====================================	death 3E	ctopic pregnancy		Month	Day Year
, P.O. res that the signed by the be detache	2	Part II. Other significant conditi	ons contributing to death but not res	sulting in the und	erlying cause given	ı in Part I.			o the cause of death?
Division of Vital Records, P.O. Box 687. To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as it	Completed	_			-		24a. Was an autopsy performed 1 Yes 2	prior to	
ital Fician:	Be	25. Was case referred to medical examiner?	Hospital: CT	ER/Outpatient 3		Death (Check only	one) ome 5 Resi	idence 6 Oth	ar.
on of V ending Phys ath. or: After thi	tion: To	1 V Yes 2 No 27. Manner of Death 1 Natural 5 Pend	28a. Date of Injury (Month, Day Year) Jul 25, 2010	28b. Time of Inju 2252 hrs		Work? 280	d. Describe how i bject shot		-
Divisi Hospital or Att 24 hours after de Puneral Directe	Certification:	3 Suicide 6 Could deter	d not be mined (Specify) Sidewalk	ne, farm, street,	factory, office building		or Town, State)		tural Route Number, City
To the Hosp within 24 hc To the Fun completely f	edical	one) 2 Medical Exar	nysician: To the best of my knowledge niner: On the basis of examination and and manner stated.						
3	Ž	29b. Signature and title of certifier	Hallan		29c. License nui O.C.M.E			d Date signed (Mugust 1, 2010	onth, Day, Year)
	f		who completed cause of death (Item 2 sistant Medical Examiner 1		eet, Baltimore,	, MD 21201			
St Regist		31. Date filed (Month, Day, Year)	37. Registrar's Signature						

OCME

		1	For State Registrar	State of Mary	yland		irtment of F tificate of D			giene 20	10	25926
Physi	ciar	/	1. Decedent's Name (First, Middle, Las)					2. Date of Dea	nth Day	Year	3. Time of Death
	dica	al .	Robert Alber 4a. Facility Name (if not institution, give				4b. City, Town, or	Location of De	July 30	2010 4c. County		2:09 PM
-/	mine		Gilchrist Center f		Care	э	Towson	Eccation of De	SCHI	Balti		
Funer Direct			053-50-8964	7. Age (In	yrs. last	birthday) Yrs.	Months Days	If Under 24 H Hours M		^h Year) 1955	9. Birthp Coupt NY	lace (State or Foreign ry)
nd how at		. ľ	Usual Residence of Decedent 10a. State 10b. County	10	c. City, T	Town or Loc	ation				10	0d. Inside City Limits
Maryla 28a-f s etified		rect	MD Carroll	I .		ksburg						1 ☐ Yes 2 ☐ No
th the		<u>a</u>	10e. Street and Number				10f. Zip Code			10g. Citizen of V	Vhat Coun	try?
eath wi		Funeral Director	2300 Kays Mill Ro	12. Was Decedent Ever	in U.S.	13. W	21048 /as Decedent of His	spanic Origin?	(Specify Yes or No-	U.S.A.	e - America	an Indian
ING Z1Z13-UU30 e filed within 72 hours after death with the Maryland tal Hyglene. of other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at event, the Medical Examiner must be notified at		2	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☒️No If Yes, Give Year or Dates.		lf lf	Yes, specify Cubar	n, Mexican, Pu	erto Rican, etc.) Puerto Ric	Blac	k, White, e	
72 hou 72 hou n "natu fedica		Completed	15. Decedent's Ed (Specify only highest gra	de completed)	4.4	(Give k	ent's Usual Occupa ind of work done d	urina most of v	vorking	Enterpr	isiness Ind	**Technical
within giene.	-		Elementary/Seconday (0-12)	4 College (1-4 or 5+)	5	Senio	NOT use retired) Direct	r		_ 5	Servi	ces
Maryland is should be filed vand Mental Hyg is marked othe raumatic event,	1	9 Pe	7. Father's Name (First, Middle, Last) Roberto Romero					18. Mother's N	Name (First, Middle, 1	Maiden Surname)	
Mary 12 should lith and IN 27 is ma			19a. Informant's Name/Relationship (Type	ne, <i>Print)</i> Wife		19b. Mailing 2300	Address (Street a	nd Number or	Rural Route Number South, Fi	City or Town, S	tate, Zip C	ode) 21048
baltimore, Marylan permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ee		1	20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	cem	etery, crem	ition (Name of atory or other place		Date /3/2010	20c. Location -	-	· ·
baltimor permit. Page 1 Department of Important. If if any injury or or	ouce.	-	4 ☐ Donation 5 ☐ Other (Specify 21. Signatur of Roberal Service License		arro	22.	Name and Addres	s of Facility P		eral Hon	e a c	Chapel, PA 21157
		+	23a. Part . Enter the disease, or comp	ications that caused the	death. D						، طب	Approximate
Physicia Medic	_		shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	metas	10-		Rengl	Can	ER		100	Interval Between Onset and Death
Examin	er		Sequentially list conditions,	Due to (or as a cor	nsequend	ce of):						
uted d ansit			if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events	Due to (or as a cor	nocquent	ce ulj.						
cate be executed physician and sthe burial-transit		Z	resulting in death) Last	Due to (or as a cor	nsequend	ce of):						
tificate I			F FEMALE:						_			
Hospital or Attending Physician: The law requires that the death certifica 4 hours after death. Functure and Experiment of Attending Physician: The law requires that the death certifica 4 hours after death. Functure Director: After this certificate has been signed by the attending pated filled in by the funeral director, page 2 should be detached for use as it	Dhurinian/N/	ysicially	3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pr 1 Live Birth 2 4 4 Pregnant at time 9 Unknown	Fetal de	eath 3 🗌	Ectopic pregnancy Other (specify)			23d. Date Mor	e of deliver	ry Day Year
vequires that the de been signed by the should be detached	Ž	<u>`</u> [`	Part II. Other significant conditions co	tributing to death but no	ot resultir	ng in the un	derlying cause give	en in Part I.				e cause of death?
requires been signatured should b	Potol	ן פופר							24a, Was a	es 2 No		ably 4 Unknown sy findings available
The law cate has page 2 s	Completed								- autop: perfor 1 ☐ Yes	nged / d	rior to com eath? Yes 2	pletion of cause of
Physician: The this certificate ral director, pag	7. 8.	ו ב	5. Was case referred to medical examiner? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \)	ospital: 1	2 ED/	/Outpatient	_ Other	ce of Death (Cf	neck only one) Home 5 🗆 Reside	· Y au	(0 (1)	NOVOICA
iding Phy th. After this	10,000		7. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day, Yea	281	b. Time of injury	28c. Injury work?	at	28d. Describe ho			Magrico
l or Atten after dea Director:	Cortificato:		3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (Sp		, farm, stree		2 2 2 1 1 0	28f. Location (St City or Town		r or Rural F	Route Number,
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After the completed filled in by the funeral	Modical	ופחוכם	(Check 2 Medical Examin	cian: To the best of my ker: On the basis of examin	nation and	d/or investig	ation, in my opinior	, death occurre	d at the time, date an	d place, and due	to the caus	se(s) and manner stated.
To the comp	2		9b. Signature and title of certifier	RNP	or my Kill		29c. License			9d. Date signed		
10		3	0. Name and address of person who co	mpleted cause of death	(Item 23a	a) (Type, Pri	nt) K9+h	myn A	ilten our	VP NO	71	210
S Regis	tate trar	3	1. Date filed (Month, Day, Year) AUG 0 3 2	32. Registrar's S		1. A	aks		11/1/01/01/		4	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 29, Day 2010 Year RUBIN 4:06 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Suburban Hospital Bethesda Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 1 M 2 TF Months Days Hours (Month, Day, Year) 579-36-5067 80 Director 1930 Washington, DC Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director or 28a-f Maryland 1 Yes 2 No Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 239 5225 Pooks Hill Road #420N 20814 United States items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces' 10 Black, White, etc 1 Never Married 2 Married Completed by 2 X No hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: white If Yes, Give "natural", 3 XWidowed 4 ☐ Divorced Year or Dates. permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical.I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) David Shapiro Rose Sahm 19a. Informant's Name/Relationship (Type, Print) Rona Eisen, Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5439 Whitley Park Terrace, Bethesda, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 D Burial 2 Cremation 3 TyRemoval from State 4 ☐ Donation 5 ☐ Other (Specify) <u>Elesavetgrad Cemetery 08/01/2010 | Washington, DC</u> 21. Signature of Fune a Service Licensee Forchitisky Hebrew Funeral Home 254 Carroll St., NW. Washington. 20012 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician/ Respiratory Failure disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Pleural Effusion Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury sician and burial-transit Fallopian Tube Carcinoma that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria on 29 live outocam Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Day Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Atrial Flutter with Rapid Ventricular Response 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed Yes 2 To the Hospital or Attending Physician: within 24 hours after death.

Jo the Funeral Director: After this certific completed filled in by the funeral director, Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 Npatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 29d. Date signed (Month, Day, Year) (5068405 July 29, 2010 me and address de fron who completed cause of death (Item 23a) (Type, Print)
David Guevara-Nieto, M.D., 8600 Old Georgetown Road, Bethesda, MD

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year) AUG 02 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

\[\begin{align*}
\text{ \text{N}} & \text{ \text{B}} & \text{B} & \text 25928 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Walter Ray Rose Medical 010 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE WASHINGTON MEDICAL GLEN BURNIE HRUNDEL INNE Age (In yrs. last birthday)
65 Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Funeral 9. Birthplace (State or Foreign Days 451-68-3841 1 🕅 M 2 🗆 F Months Hours Min. Director Country) 0/12/1944 Texas Usual Residence of Decedent show permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b, County 10c. City, Town or Location Director 10d. Inside City Limits 1 🗆 Yes 2 😾 No Anne Arundel Millersville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 516 Ski Lane 21108 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Bace - American Indian Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ XNo Specify: White Completed 3 Widowed 4 Divorced Specify: 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working ute DO NOT use retired) Carpenter Elementary/Seconday (0-12) College (1-4 or 5+) 02 Building To Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Rose Violet Kay Boyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Rose Spouse 516 Ski Lane Millersville, MD 21108 1305F 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Our Lady of the Fields08/02/2010 Millersville, MD . Signature of up all Service Lice 851 Annapolis Road Gambrills, MD 21054 22. Name and Address of Facility Hardesty Funeral Home P.A. Tall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner -AMAZ Sequentially list conditions, if any, leading to in rediate cause. Enter Underlying Examiner Due to (or as a consequence of, attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Year signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 Yes 2 No 3 Probably 4 hknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy certificate 2 10 No 21 NO Yes 1 Yes 25. Was case referred to medical BB | 26. Place of Death (Check only one) examiner? 2 - No Other: ျှ 1 🗌 Yes 1 npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? Accident
Suicide 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTMONO WASHITGO GLEN MCDI CITE 31. Date filed (Month, Day, Year) Registrar's Signatur State AUG 03 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 | 0

Certificate of Death Reg. No.

			1 - For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	ertificate of De	alth and Mental H eath	lygiene 0 0	25929
	Physici /Medi		Decedent's Name (First, Middle, Last Violet Emma Ran	,			2. Date of I Month July	Death Day Year 29, 2010	3. Time of Death 10:00 P M
	Examir		4a. Facility Name (If not institution, give Washington Adver	. ,	ltal	4b. City, Town, or Loc	cation of Death Park	4c. County of Death Montgome	
	Funeral Director		5. Social Security Number 6. St 216–44–3201 1 Usual Residence of Decedent	ex 7. Age □M 2 🖾 F	(In yrs. last birthday 97 Yrs.		Under 24 Hrs. 8. Date of I Hours Min. (Month, Decembe	Birth Day, Year) 9. Birth Court 25, 1912 Upper	place (State or Foreign ntry) Middletown ,PA
	the Maryland 28a-f show otified at	Director	10a. State 10b. County Maryland Prince (10e. Street and Number		10c. City, Town or L	ille			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	h with 23a or st be		4110 Queensbury	Road		10f. Zip Code 207	781	10g. Citizen of What Cou USA	ntry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene and Inforcative it it is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is incorrect. It is notified a once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 □ Yes 2 図 No If Yes, Give Year or Dates:			anic Origin? (Specify Yes or t Mexican, Puerto Rican, etc.) Specify:	14. Race - Ameri Black, White, Specify: Whi	etc.
21215-0036	within 72 ho ene. than "natur he Medical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Giv.	edent's Usual Occupation e kind of work done durir DO NOT use retired)		16b. Kind of Business/Ir	•
land 2	Ild be filed a fental Hygi rked other tic event, to	To Be Co	17. Father's Name (First, Middle, Last) Reno Lincoln Mos	sier, Sr.		18.	. Mother's Name (First, Midd	lle, Maiden Surname)	
, Maryland	and 2 shou ealth and N n 27 is mai		19a. Informant's Name/Relationship (7			ing Address (Street and	Number or Rural Route Num 7 Road, Hyatts	nber, City or Town, State, Zi	
altimore,	t. Pages 1 tment of He tant: If iten ijury or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		Laurel	matory or other place)	Date 8/2/2010	20c. Location - City or To Smock, Penns	
Ba	Departi Departimbor Impor any ir		21. Signature of Funeral Service Licens	see Has	0	2. Name and Address of	ral Home, P.A	4739 Balti	more Avenue
	Certificate be executed Administration and market and see as the burial-transit	edical Examiner	23a. Part1. Enter the disease, or compshock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Acute Ren Due to (or as a b. Congestiv	nal Failu consequence of): ve Heart consequence of): consequence of):	re	uch as cardiac or respiratory	arrest,	Approximate Interval Between Onset and Death
ă į	death certi e attending d for use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of deliv Month	ery Day Year
rds, P.	iaw requires mat me or as been signed by the 2 should be detached	ρ	Part II. Other significant conditions co	ntributing to death but	not resulting in the ι	ınderlying cause given in		d tobacco use contribute to t	
Ť,	ate has	e Completed	25. Was case referred & medical				per 1 □ Yes	formed? prior to co death? 2 No 1 Yes	psy findings available mpletion of cause of 2 No
от 2	r nysician: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 ÎZ No	Hospital: 1 Inpatient	2 ☐ ER/Outpatie	Other	Place of Death (Check only Under the Place of Death (Check only) Under the Place of Death (Check only)		fy)
_	n 0 0	Certification:	27. Manner of Death 1 Natural 2 Accident	28a. Date of Injury (Month, Day, 1	/ - At home, farm, st	Work? M 1 □ Yes	2 □No 28f. Location	e how injury occurred (Street and Number or Rure	al Route Number,
ה י	within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun		29a. Certifier (Check only 2 Medical Exam	building, etc. 'sician: To the best of iner: On the basis of e	my knowledge, dea	th occurred at the time, onvestigation, in my opinion	City or To	own, State)	stated.
	within 2 To the !	Medical	29b. Signature and title certifier	and manner state	·d.	29c. License nur	mber	29d. Date signed (Month, 7/30/2	
R	15		30. Name and address of person who c	ompleted cause of dea	th (Item 23a) (Type,	Print) NINA,	M. D 760 Tak	O Carroll Ave	enue 20912

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)
AUG 0 3 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene 2010

uentin Deante	1101	1- For State	r Maryland / Dep Ce	ertificate of D		-iilai i iy		j. No.	
Physician/		Registrar 1. Decedent's Name (First, Middle,Last)					2. Date of Death		3. Time of Death
ledical Examiner		Quentin Dean			City Town of Location	on of Dooth	July 29, 20	10	1538 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 9800 Loch Raven Drive Towson 4c. County of Death Baltimore County							
Funeral		Social Security Number 6. Sex				nder 24Hrs.	1	(MM/DD/YYYY) 9. Bir	thplace (State or
Director		213-27-3745 1 M 2 F 23 Yrs. Molitis Days 10013 Mill 5-10-1987 Country) MD							
yne	Il Director	Usual Residence of Decedent 10a. State							
*		MD		Balti	more				1 Yes 2 No
Maryland 28a-f show 1 at once.		10e. Street and Number		10	Of, Zip Code		100	g. Citizen of What Coul	ntry?
th the decision that the decision of the decis		5754 Cedonia A			21206			USA	
ath wi items	Funeral	11. Marital Status 1 X Never Married 2 Married	12. Was Decedent Ever in Armed Forces?		ecedent of Hispanic (specify Cuban, Mexic			14. Race - Ameri White, etc.	can Indian, Black,
ifter de il", or	by Fu	3 Widowed 4 Divorced If	1 Yes 2 X No	1 Yes 2 No specify:				ıck	
hours a	eted b	15. Decedent's Education (Specify only			Isual Occupation (Gir of working life, DO NO			16b, Kind of Business/l	ndustry
36 nin 72 l than " dical I	plet	Elementary/Secondary (0-12)	College (1-4 or 5+) 4 +	Pot	ail			Private	2
5-00 ed with tygien other	Comple	17. Father's Name (First, Middle, Last)	41	I Ket		her's Name (First, Middle, Ma		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	Clinton A. Rob			_		Parke		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygien 172 hours after death with the Maryland Important. If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	To	19a. Informant's Name/Relationship (Typ Cecelia Robinso		36996	West Lak	selan	d Dr. 1	er, City or Town, State Mechanics	ville MD
ore, solution of Health fritem		20a. Method of Disposition 1 X Burial 2 Cremation 3	Removal from State	 Place of Disposition crematory or other 	(Name of cemetery, place)		Date	20c. Location - City or	Town, State
Baltimore, permit. Pages I an Department of Hee Important: If ite		4 Donation 5 Other Specify:	S	acred He				Bushwood	
Balt permit Depart Impor Injury	y	21 Signature of Funeral Service License MULLIY CENUSCO	reTonic		e and Address of Fac · Old Was			Tonic Fur Waldorf	neral HOme MD 20601
Physician /Medical		23a. Part I. Enter the disease, or complicate failure. List only one cause on each	ations that caused the deal line.	th. Do not enter the r	node of dying, such a	s cardiac or	respiratory arres	t, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease a. Drowning Death or condition resulting in death) Due to (or as a consequence of):							
		Sequentially list conditions, b							
	nine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause Circumstation to historical control of the contro							
ecuted and transit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):							
rial is	Medical	UNPENDED AMENDED							
3760 ficate b g physics s the bu	n/Me	23b. Was decedent pregnant in the	23c. If yes, outcome of pre		leath 3 Ecto	opic pregnan	CV	23d. Date of delivery	ay Year
30x 6876 leath certificate e attending phy for use as the l	icia	past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (Specify)							
Box the death of y the attenty y the attenthe for us	Physician/N	Part II. Other significant conditions	9 Unknown	resulting in the unde	dving cause given in	Part I	23e Did tob	acco use contribute to	the cause of death?
ires that the signed by	Š	Tartin Outer Significant Contactions of	Similaring to death but not	resulting in the unde	nying caase given in	1 0, (1,		2 ✓ No 3 Prob	
cords, law require has been since 2 should to	ompleted						24a. Was an autopsy		topsy findings available ompletion of cause of
of Vital Records, ge Physician: The law requir this certificate has been s meral director, page 2 should I	duo								
12 13 14	ပ	25. Was case referred to medical			26.Place of Dea		nly one)		
Yit Physici r this c	To B	1 🗸 Yes 2 No	pital: 1 Inpatient 2	ER/Outpatient 3	DOA Other			esidence 6 🗸 Other	Scene
nding Ph h. h. e funeral		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day, Year) FOUND:	28b. Time of Injury FOUND:	28c. Injury at Wo	_ IS	ubject drown	w injury occurred ned	
Division tal or Attendi rs after death. al Director: /	ficat	2 🗸 Accident Investigation	Jul 29, 2010 28e. Place of Injury - At	1537 hrs home, farm, street, fa		etc. 2			ral Route Number, City
Divis ospital or A hours after uneral Dire	Certification:	3 Suicide 6 Could not be determined (Specify) Lake or Town, State) 9800 Loch Raven Drive, Tows						te) en Drive, Towson, M	ID
the H hin 24 the Fu	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Replacement of the cause(s) and manner as stated.							
To To To Com	Mec	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed					29d. Date signed (Mor		
		Pote (in -	ell.		O.C.M.E.			July 30, 2010	
20.	30. Name and address of person who completed cause of death (Item 23a)								
DB6	210	Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Pey, Xed P. O. 1.0. 32 Registrar's Signature 33. Date filed (Month, Pey, Xed P. O. 1.0. 32 Registrar's Signature 33. Date filed (Month, Pey, Xed P. O. 1.0. 32 Registrar's Signature 33. Date filed (Month, Pey, Xed P. O. 1.0. 32 Registrar's Signature 33. Date filed (Month, Pey, Xed P. O. 1.0. 32 Registrar's Signature 33. Date filed (Month, Pey, Xed P. O. 1.0. 33. Registrar's Signature 34. Date filed (Month, Pey, Xed P. O. 1.0. 34. Registrar's Signature 34. Date filed (Month, Pey, Xed P. O. 1.0. 34. Registrar's Signature 34. Date filed (Month, Pey, Xed P. O. 1.0. 34. Registrar's Signature 34. Date filed (Month, Pey, Xed P. O. 1.0. 34. Registrar's Signature 34. Date filed (Month, Pey, Xed P. O. 1.0. 34. Registrar's Signature 34. Date filed (Month, Pey, Xed P. O. 1.0. 34. Registrar's Signature 34. Date filed (Month, Pey, Xed P. O. 1.0. 34. Registrar's Signature 34. Date filed (Month, Pey, Xed P. O. 1.0. 34. Registrar's Signature 34. Date filed (Month, Pey, Xed P. O. 1.0. 34. Date filed (Month, Pey, Xed P. O. 1.0. 34. Date filed (Month, Pey, Xed P. O. 1.0. 34. Date filed (Month, Pey, Xed P. O. 1.0. 34. Date filed (Month, Pey, Xed P. O. 1.0. 34. Date filed (Month, Pey, Xed P. O. 1.0. 34. Date filed (Month, Pey, Xed P. O. 1.0. 34. Date filed (Month, Pey, Xed P. O. 1.0. 34. Date filed (Month, Pey, Xed P. O. 1.0. 34. Date filed (Month, Pey, Yed P. O. 1.0. 34. Date filed (Month, Pey, Yed P. O. 1.0. 34. Date filed (Month, Pey, Yed P. O. 1.0. 34. Date filed (Month, Pey, Yed P. O. 1.0. 34. Date filed (Month, Pey, Yed P. O. 1.0. 34. Date filed (Month, Pey, Yed P. O. 1.0. 34. Date filed (Month, Pey, Yed P. O. 1.0. 34. Date filed (Month, Pey, Yed P. O. 1.0. 34. Date filed (Month, Pey, Yed P. O. 1.0. 34. Date filed (Month, Pey, Pey, Pey, Pey, Pey, Pey, Pey, Pey							
Regis	tate trar	31. Date filed (Month, Pey, Xea 2010	Deneva	A. Jak					

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year May Ethel Reed 7:31AM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Huspice At ISD Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign Country) Pennsylvania 8. Date of Birth **Funeral** 1 M 2 🐴 Hours Min. 220-26-2053 80 03/22/1930 Director Jsual Residence of Decedent 10a. State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at 10d. Inside City Limits Funeral Director Wicomico Salisbury Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 113 Kendall Street 21804 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 X No altimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: white "natural", 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) of Health and Mental Hygiene. If item 27 is marked other tha other traumatic event, the seamstress clothing manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Roy D. Lapp Ethel M. Diffenderfer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joshua Reed/spouse 113 Kendall St., Salisbury, MD 21804 Important: If item any injury or othe 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Springhill Memory Gardens 4 Donation 5 Other (Specify) 8?7/2010 Hebron, MD 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) sician and bunial-transit Due to (or as a consequence of): resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be ex within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the bunal Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 ☐ Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 🗷 Other (Specify) 1 Yes ည 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes Investigation 6 Could not be Accident 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29505 31-2010

Registrar

M.D.; 5302 CHINABERRY DR., SALISBURY, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AUG 0 4 2010

GREGORIOM.

31. Date filed (Month, Day, Year)

			For State Registrar	State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2010 2593						
	Physicia	an/	Decedent's Name (First, Middle,	Last)				2. Date of Dea Month	th Day Year	3. Time of Death
	Medie Examir		4a. Facility Name (if not institution, BALTIMORE WASHING		0		Location of Death	AUGUS	4c. County of Death ANNE A	1
ı	Funeral Director				yrs. last birthday) 42 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day	0.00	nplace (State or Foreign
	and show dat	tor	Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Loc	ation				10d. Inside City Limits
	death with the Maryland items 23a or 28a-f sho ner must be notified at	Director	MD 10e. Street and Number		BALT	MORE 10f. Zip Code	<u> </u>	Т	10g. Citizen of What Cou	1 Yes 2 □ No
	ath with tims 23a must be	Funeral	3541 4Th.	37.	in II C 12 M	ZIZ			0.5.6	1.
DARLENE L. Maryland 21215-0036	after II", or xami	by	11. Marital Status 1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☑ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	1f	Yes, specify Cubar	spanic Origin? (Spent, Mexican, Puerto I	city yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	
	filed within 72 hours al Hygiene. I other than "natura went, the Medical E.	Completed	15. Decedent (Specify only highes Elementary/Seconday (0-12)		(Give k	ent's Usual Occupa ind of work done di NOT use retired)	uring most of workir	ng	16b. Kind of Business I	ndustry
	should be filed within 7: and Mental Hygiene. is marked other than aumatic event, the Me	To Be (17. Father's Name (First, Middle, La	ENSTEIN		MCMA	18. Mother's Name	(First, Middle, M	Maiden Surname)	DME
DARLE Maryland	2 should be file th and Mental H 27 is marked o traumatic eve		19a. Informant's Name/Relationshi		19b. Mailin	1	N		City or Town, State, Zip	Code)
	of :: a		20a. Method of Disposition 1 Burial 2 Cremation	Removal from State	20b. Place of Dispos cemetery, crem		С	Date	20c. Location - City or T	
REESE Baltimore,	permit. Page Department of Important: If any injury or once.		4 ☐ Donation 5 ☐ Other (Sp. 21. Signatus of Fineral Service Lie	10	J. ARUNDE 22.	Name and Address	s of Facility Date	raheat	Y FUNERAL	
	<u> </u>	Н	23a. Part 1. Enter the disease, or c shock, or heart failure. List on	mprications that caused the	death. Do not enter	the mode of dying	, such as cardiac or	ASADE r respiratory arre		Approximate
4	Physician Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a cor	i Sch	omia		*		Interval Between Onset and Death
	Examiner	ier	Sequentially list conditions if any, leading to immediate	Due to (or as a cor	Lyenra	wid	val h	who	a	
	ite be executed hysician and he burial-transit	Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	c Due to (or as a consequence of):						
09/	ate be ex physician the buria		,	d						
. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi		FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of pr 1 Live Birth 2 4 Pregnant at time 9 Unknown	Fetal death 3 🗌	Ectopic pregnancy Other (specify)	,		23d. Date of deliv	very Day Year
ls, P.0	uires that th signed by Id be deta	۾	Part II. Other significant condition	s contributing to death but no	ot resulting in the un	derlying cause give	en in Part I.*		pacco use contribute to t	. 1
Division of Vital Records, P.O.	he law requ ite has beer age 2 shou	Completed	A SCIES Alcohol Dependence 24a. Was an autopsy finding prior to completion of death? 1 Yes 2 No							ompletion of cause of
/ital	s certifica	To Be (25. Was case ferred to medical examiner? 1 \(\sum \) Yes 2 \(\sum \) No	Hospital:	2 ER/Outpatient	0.0	ce of Death (Check	only one)	ence 6 Other (Specif	
n of \	iding Phy th. After this funeral o		27. Manner of Death 1 Natural 5 Pending 2 Accident Investiga	w injury occurred	y)					
Divisio	al or Atter s after dea il Director id in by the	Certificate:	3 Suicide 6 Could no 4 Homicide determin	t be 290 Place of Injury			es 2□No	8f. Location (Str City or Town	reet and Number or Rura , State)	I Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	(Check	hysician: To the best of my k aminer: On the basis of examin urse Practioner: To the best	nation and/or investig	ation, in my opinion	, death occurred at t	the time, date and	d place, and due to the ca	ause(s) and manner stated.
	To the within com		29b. Signature and title of contifier	m_M	1	29c. License	number	2	9d. Date signed (Month, August	Day, Year)
_			30. Name and address of person wi	Phasm 3	OI HOSE	Hal D	6 lon	Bur	Im au	20161
	Stat Registra	e ar	AUG 18201	32. Registrar's S	ic fature	V	,		2	

			For State	State of M	1arylan	d / Depa	artment of F	lealth ar	nd Men	tal Hyg	iene 1	N	25933
			Registrar 1. Decedent's Name (First, Middle			Cer	tificate of L	veatn		ate of Deat	eg. No.		
	Physicia Medic		Varden W.Sti							Month USU		ear O (O	3. Time of Death ρ
	Examin		4a. Facility Name (if not institution,				4b. City, Town, or		Death	0	4c. County of		
man di			Washington Cour 5. Social Security Number			and the lands of the col	Hagers If Under 1 Year	town, If Under 24	Ura Lo B	- CD: 0	Washi		
	Funeral Director		213-40-4713	6. Sex 1 ☑ M 2 ☐ F	71	st birthday) Yrs.	Months Days			ate of Birth Month, Day,	1939 G	Count Ceen	lace (State or Foreign ry) castle, PA
	nd how at	=	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Loc	eation					11	Od. Inside City Limits
	larylar 3a-f s iffied	Funeral Director	MD Washi	ington	Sh	arpsbu	rg					İ	1 ☐ Yes 2 🔀 No
	the M	Dir	10e. Street and Number				10f. Zip Code			1	0g. Citizen of Wh	at Coun	try?
	s 23a	nera	16836 Shaffer	Road			21782				US		
	death ritem nern		11. Marital Status	12. Was Decedent Armed Forces	?		Vas Decedent of Hi Yes, specify Cuba	spanic Origin n, Mexican, P	n? (Specify Y Puerto Rican	es or No- , etc.)	14. Race - Black.	America White, e	
39	al", o	d b	1 ☐ Never Married 2 ♣ Marrian 3 ☐ Widowed 4 ☐ Divorced	If You Give Z	No	1	☐ Yes 2 😾 No	Specify:			Specify:	wh	ite
ŏ	hours natur dical I	olete		nt's Education	_		ent's Usual Occupa		A	- 1	16b. Kind of Busi	ness Ind	ustry
Maryland 21215-0036	nin 72 ne. .han " e Mec	Completed by	Elementary/Seconday (0-12)	st grade completed) College (1-4 or	5+)	life. DO	ind of work done d NOT use retired)	uring most of	r working				
7	d with tygier ther t nt, th	farmer pro								produc	ce i	arm	
Varden W.Stine, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Virginia L. Stine 16836									s Name <i>(Fir</i> s .e Unk:		iaiden Surname)		
ary.	nould nd Me s mari		19a. Informant's Name/Relationsh			19b. Mailin	g Address (Street a				City or Town, Stat	e, Zip C	ode)
Σ	id 2 st salth a n 27 is er tra		Virginia L. St	ine		1683	6 Shaffe	r Rd.	Shar	psburg	g, MD 2	1782	
ore	e 1 an of He If iten ir oth		20a. Method of Disposition 1X Burial 2 Cremation	3 Removal from State		lace of Dispos	sition (Name of natory or other place	e)	Date		20c. Location - Ci	ty or To	wn, State
<u>ä</u>	. Page tment tant: I		4 Donation 5 Other (S	pecify)	-		Iill Ceme				Greencas		
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if them 27 is marked other than "naturaly, or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Functial Service L	icensee			Name and Addres						ral Home
			23a. Part 1. Enter the disease, or	complications that cause	d the death								Approximate
P	hysician/	3 3	shock or heart failure. List of Immediate Cause (Final disease or condition			£ 11	J TRACR	ANIA	1 HE	MOR	RHAGE		Interval Between Onset and Death
	Medical Examiner		resulting in death)	Due to (or as	a consequ	ence of):							
	Lxammer	-e	Esquentially list conditions,				ORT	ACID	0515			-	
٠.	ed nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as	a consequ	ence ot):							
0.	xecut n and al-trar	Exa	that initiated events resulting in death) Last	C. Due to (or as	a consequ	ence of):						+	
00	e be e ysicia ie buri	dical		d									
876	tificat ng ph e as th	03	IF FEMALE:	45								_	
Division of Vital Records, P.O. Box 687	th cer ttendii or use	Completed by Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal	Ideath 3	Ectopic pregnanc	у			23d. Date of Month		ry Day Year
ğ.	the a	ıysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant 9 ☐ Unknown		eath 5 ∟	Other (specify)				Wient		Day
0	that the	y Ph	Part II. Other significant condition	9			nderlying cause giv	en in Part I.	2	23e. Did tob	acco use contribu	ite to the	e cause of death?
S,	urres 1 n sigr uld be	ed b	PULMONA	RY EN	BOL	ţ.				1 🗌 Ye	es 2 🗆 No 3	☐ Prob	ably 4 🛛 Unknown
Ö	iw req is bee 2 shoi	plet							:	24a. Was an autops		re autop	sy findings available
Rec	The la ate ha page	Som							_	perform	ned? dea	th?	2 No
ta .	cian: ertifica ector,	Be (25. Was case referred to medical examiner?	Hospital:				ce of Death (
<u> </u>	Physic this c al dire	요	1 Yes 2 No	1 X Inpa		ER/Outpatien 28b. Time of	t 3 DOA Othe	4 L Nursi			nce 6 Other	Specify)	
ם יי	iding th. After funer	Certificate:	1 1 Natural 5 Pendin 2 Accident Investig	g (Month, D	ay, Year)	injury	work'		- 1	Jescribe nov	w injury occurred		
Sio	Aften er dea ector: by the	rtifi	3 Suicide 6 Could	not be 28e. Place of In			et, factory, office				eet and Number o	r Rural i	Route Number,
<u>`</u>	tal or ins after al Dir led in			building, e	tc. (Specify)	'				Gity or Town,	, State)		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. Within 24 hours after death. Completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 Medical E	Physician: To the best o xaminer: On the basis of	examination	and/or invest	igation, in my opinio	n, death occui	irred at the tii	me, date and	place, and due to	the cau	se(s) and manner stated.
	o the	Σ	only one) 3 L Certifying 29b. Signature and title of certifier	Nurse Practioner: To the	e best of my	knowledge, d	eath occurred at the 29c. License		nd place, and		cause(s) and mann Od. Date signed (A		
	F % F 0		MOHAMM	€0 A212	_		06	689	2				
	7		30. Name and address of person v	who completed cause of	death (Item	23a) (Type, P	Dia attetan	5+	1100	csh	2 110	``	740
	Stat	e	Mohammed 1 31. Date 1960 17,802010	ZIZ MO	OD L	air	ile w	,,,,,	ringe	سان ا د د	11,1413	041	110
	Registra	ar	AND TO SOLO	CON.	7	- Garage A							

		1 - For State Registrar	State of Man		artment of F			gie De	0 25934
Physic		1. Decedent's Name (First, Middle, La Catherine	L. Smiths	on			2. Date of Dea Month August	Dav	3. Time of Death 9:18 A
/Med Exami		4a. Facility Name (If not institution, given			4b. City, Town, o	r Location of Death		4c. County	
		19714 Grays				te Hall			timore
Funeral Director			Sex 7. Age (I 1 ☐ M 2 🗹 F	n yrs. last birthday) 72 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day May 3,	1938	9. Birthplece (State or Forei Country) Maryland
/land		10a. State 10b. County	10	Oc. City, Town or Lo	ocation				10d. Inside City Limit
a-fsh	iot	MD Harfo	ord	White	eford				1 □ Yes 2 🌠 N
ih the	Director	10e. Street and Number			10f. Zip Code		1	10g. Citizen of V	What Country?
a 23a		4930 Gracetor			211			US	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or Itema 23a or 28a-f show any injury or other traumatic event, it a Mudical Examiner must be notified.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	12. Was Decedent Eve Armed Forces? 1 Tyes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No	lispanic Origin? (Spi an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		e - American Indian, ck, White, etc. White
72 ho	ted	15. Decedent's E		16a. Dece	dent's Usual Occup	ation		16b. Kind of Bu	usiness/Industry
d within 72 hours at giene. Than "natural", or than "natural", or the Medical Exam	Completed	(Specify only highest gri Elementary/Secondary (0-12)	College (1-4or 5+)			during most of work: d)	ing		
e filed within al Hygiene. other than vant, the Me		17. Father's Name (First, Middle, Last	n)	Sel:	f-Employ	7ed 18. Mother's Name	Wind A Statella	Foo	
nd 2 should be file the and Mental Hy 27 is marked oth traumatic evant	Be	Other McClai					Grove	маювп Битат	/e)
2 should and Men is marke sumatic	2	19a. Informant's Name/Relationship (19b. Mailir	na Address (Street	and Number or Rura		r City or Town	State. Zin Code)
and 2 and 2 and 2 and 2 and 2 and 2 is		Edna M. Bart	•						
of Heal		20a. Method of Disposition		20b. Place of Dispo	sition (Name of	! .	_		City or Town, State
Page nent c		1 X Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specific or Company)	Pemoval from State (y)	West Libe Methodist	cemeter	ea 7 Augus	t 17,2010	Whit	e Hall, MD
permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service Lice		22	Name and Addre	ss of Facility J.			in Mortuary own, PA 1736
Physician / Medical Examiner behavioral and bhysician and bhysician and the bruial-transit	edical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a co	onsequence of).	adenoca	ramons (7 Gel	Blad	dan
The law requires that the death certifics the law requires that the death certifics at the has been signed by the attending proage 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2/2 No 9 ☐ Unknown	23c. If yes, out <i>come</i> of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Dat Mor	te of delivery nnth Day Year
w requires that been signed E	by	Part II. Other significant conditions of	contributing to death but n	ot resulting in the u	nderlying cause give	en in Part I.			ribute to the cause of death? 3 Probably 4 Unknow
The law requires the state has been signed page 2 should be considered.	Completed						24a. Was a autops perform	sy p med? d	Were autopsy findings available prior to completion of cause of death?
Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hagaital:			26. Place of Death			util Rendone
Physi this o	2	1 Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatien		4 Nursing Hol			er (Specify)
ding h. After funer	tlon	1 Natural 5 Pending	28a. Date of Injury (Month, Day Ye	28b. Time of Injury	Worl	γat (? Yes 2 □ No	28d. Describe ho	ow injury occurr	ed
l or Attending Physician: after death. Director: After this certifica in by the funeral director, p	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	e One Class of Injury	- At home, farm, str Specify)			28f. Location (St City or Town	treet and Numbern, State)	er or Rural Route Number,
To the Hospital or Attending within 24 hours after death within 24 hours after death completely filled in by the fune tone	Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exert	ysician: To the best of m niner: On the basis of exa and manner stated	amination and/or inv	occurred at the time vestigation, in my of	ne, date and place, a pinion, death occurre	and due to the ca	ause(s) and ma ate and place, a	nner as stated, and due to the cause(s)
To the within To the comp	Me	29b. Signature and title of certifier	Ilser		29c. License	9 number 510 783 4		9d. Date signed	d (Month, Day, Year)
10		30. Name and address of person who				1	1 - 1	,727	
				S6Web!		+awn	over	1 (/)2	.)
Sta Regist	_	31. Date filed (Month, Day, Year)	Server A.	Signature	•				
HMH 17 Bev 1/2		AUG 182010 /	sever p.	19 min					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ $\mathrm{Ju}^{ ext{Month}}_{\mathbf{v}}$ Ruth 2010 Stein 9:48 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yo May 20, Birthplace (State or Foreign Country) **Funeral** Year) - 1927 Days Hours 1 M 2 X Director 080-20-4221 83 May New York Usual Residence of Decedent or 28a-f shov 10a. State "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 531 Rando1ph Road #336A 20904 United States 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black. White, etc. ģ 1 Never Married 2 Married Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed Specify: 3 Widowed 4 Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Own Home <u>Homemaker</u> permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Sam Gordon Fannie Meinhart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Felice Stein/Daughter 531 Randolph Road # 336A, Silver Spring, MD 20904 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) 8/6/2010 Balitmore Crematory Baltimore, MD 21. Signature of Funeral Service Licensee Simple Tribute M01463 22. Name and Address of Facility 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. Error the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of leart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ Acute Myocardial Infaction disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Hypertension Sequentially list conditions Examine any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician action completed filied in by the huneral director, page 2 should be detached for use as the burial-transit the attending physician at the hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year 1 Yes 2 L been signed by the should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. To Be Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? ☐ Yes 2 🔀 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🗆 No Other: 24 hours after death.

Funeral Director: After this leted filled in by the funeral dil 1 Inpatient 2 🛭 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D67355 7/28/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Daniel K. Sherk, 1500 Forest Glen Road, Silver Spring, MD 20902 31. Date filed (Month, Day, Year) State

Registrar

AUG 04

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieneo 25936 State
Registra AMEND#1perMD, 8/4/10, BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death WILLIAM R. SHERWOOD III Physician/ Month Day AUGUST Medical :10P 2010 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth

Jan • 6, 1925 **Funeral** 9. Birthplace (State or Foreign Months Days Hours 579-26-0483 1 ★ M 2 □ F 85 Washington D.C. **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No Maryland Frederick Frederick 10e. Street and Number ō 10f. Zip Code 10a. Citizen of What Country? 23a Funeral 5184 Boscombe Court United States 21703 items ? filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. WWII 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ò by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: "natural" Specify. Completed 3 XWidowed 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " College (1-4 or 5+) Elementary/Seconday (0-12) Insurance Agent Acacia Life Insurance æ Department of Health and Mental H Important: If item 27 is marked oth any injury or other transponen 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ William R. Sherwood Jr. Jeannette Howe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly Angell (Niece) 5184 Boscombe Court Frederick, MD 21703 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 💢 Cremation 3 🗆 Removal from State August 2010 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crem. 21. Signature of Funeral Service Lices 22. Name and Address of Facility DeVol Funeral Home weter 10 East Deer Park Drive Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ disease or condition resulting in death) 100 Medical Due to (or as a cons due ce of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Innerial Innerial investion, page 2 should be detached for use as the burial-transit 10 VO 0 that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Month Pregnant at time of death Dav Year 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: ျ 1 🗌 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifier

Myuna Hee

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

400

29c. License number

MDD 35106

Frederick, mo 21701

29d. Date, signed (Month, Day, Year)

2010

Amend Item 17 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2 0 1 0 1 - For State Registrar 25937 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death 2010 Physician/ July Map 30, 3:02 Рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Golden Living Center Westminster Carroll 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🔀 F 86 4/20/1924 Westminster, MD **Director** 219-14-9674 Yrs Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director be notified 1 Yes 2 No Carroll Westminster MD 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 107 Elaine Ave. 21157 U.S.A. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14. Race - American Indian, Black, White, et ö ģ 1 Never Married 2 Married Yes 2 XNo Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify. Specify 3 ₩ Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Homemaker Own Home permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Elmer F. Schaefer Julia A. Gist El,er F. Schaefer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Royte Number, City or Town, State, Zip Code) 107 Elaine Ave., Westminster, MD 21157 Harold Stultz, Jr. Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Evergreen Memorial Gd. 8/5/10 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Finksburg, MD 4 Donation 5 Other (Specify) 21. Signatur 22, Name and Address of Facility Pritts Funeral Home & Chapel, PA 412 Washington Rd., Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Pregnant at time of death Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 2 🗆 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and titl 29c. License number 29d. Date signed (Month. Dav. Year) WJL D0059552 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WESTMINSTER POOLE RD MD 21157 BUNGOEN JEA 31. Date filed (Month, Day, Year) State 32. Re Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2:55 ам Geraldine Elaine Summers July 30, 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's 4312 74th Ave. Hyattsville H Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day. | Hours | Min. | June 30, 9. Birthplace (State or Foreign 5, Social Security Number 7. Age (In yrs. last birthday) 1947 **Funeral** 1 □ M 2 X F 63 Maryland 579-62-2541 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 and 2 should be filed within 72 hours after death with the Marylan Health and Mental Hygiene. I have set is marked other than "natural", or Items 23a or 28a-f show ther traumatic event, the Medical Examinator must be inclifted at 1 TYes 2 TNo Maryland Prince Georges Directo Hyattsville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 4312 74th Ave. 20784 USA by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🗷 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Nursing Assistant Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Robinson Mary Hampton Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Kendrick Alton Summers / Husband 4312 74th Ave., Hyattsville, Maryland 20784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Maryland Veterans Cemetery Aug. 5, 2010 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lyles Funeral Service P.O. Box 397, Purcellville, VA 20134 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METASTATIC BREAST CANCER **Physician** /Medical Due to (or as a consequence of) **Examiner** RESPIRATORY FAILURE DUE TO LUNG LESIONS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of); P.O. Box 68760, attending physician for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live birth 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 💆 No 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown cate has been signed by , page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 3 ☐ Probabiy 4 📶 nknown 1 □ Yes 2 □ No. Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 Yes 1 ☐ Yes director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA Certification: To After this funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Yeer) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No М 24 hours after death. Funeral Director: A 2 Accident the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 hor To the Fune completely fi To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier M, D entoman MD037655 July 30, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Irina Veytsman, M.D., 110 Irving Street NW, Washington, DC 20010 32 Registrar's Signature 31. Date filed (Month, Day, Yeer) State Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. N 2010 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Mary L. Singleton Ju1y 8:25 P M 19,2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hill Haven Nursing Home Adelphi Prince George's If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours 1 □ M Director 578**-**66-2057 12/16/1915 Georgia Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f show notified at 1KIYes 2∏No Director Maryland Prince George's Adelphi 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? item 27 Is marked other than "natural", or Items 23a or other traumatic event, the Medical Examiner must be 3210 Powdermill Road Funeral 20783 United States Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. and 2 should be filed within 72 hours after tealth and Mental Hygiene.

77 Is marked other than "natural", or Ite 1 ∐ Yes 2 🔀 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 X No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. q 3 X Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Review and Herald Elementary/Secondary (0-12) College (1-4or 5+) Year Proof Reader Publishing Association 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fred Dixon Miller Ruth Jackson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health em 27 Alvin Singleton/Son 401 River Wood Drive, Fort Washington, Maryland 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important; If it any injury or conce. 1X Burial 2 ☐ Cremation 3 Removal from State Huntsville,Alabama 4 ☐ Donation 5 ☐ Other (Specify) Oakwood Memorial 07/30/2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Avenue, N.W. Washington, D.C. 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Alzheimer's Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner certificate be executed physician and s the burial-tran resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending p 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4☐Pregnant at time of death 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Hypertension, Glaucoma, Transient Ischemic Attack, 1 ☐ Yes 2 TXNo 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Depression 24a Was an autopsy performed? Yes 2X No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Inpatient 1 ☐ Yes 2X No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 24 hours after death. 1 🔼 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide thin 24 hours af 29a. Certifier 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) D55559 July 21, 2010 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Thomas Maslen, MD

AUG 02 2010

31. Date filed (Month, Day, Year)

Registrar's Signature

7525 Greenway Center Drive, Greenbelt, Maryland 20770

		Plea	ise Type or										
		For State Registrar		f Marylan	id / Depa <i>Cer</i>	artment o tificate o	f Health f Death	and M	lental Hy	giene Reg. No.		0	25940
Physicia		1. Decedent's Name (First, Middle Mary Elizabe							2. Date of De July	ath 2 9 ay	201	ar	3. Time of Death 12:50A M
Medic Examin		4a. Facility Name (if not institution				4b. City, Towr	n, or Location	of Death	3417		County of [12.JOH
	Н	Anne Arundel 5. Social Security Number	Medical 6. Sex	Cente		Anna If Under 1 Ye	apolis		8. Date of Bir		Anne		
Funeral Director		213-26-6412	1 □ M 2 X □ F	0 1 7	Yrs.	Months Da		Min.	reb 2		28 M	Countr [ary	ace (State or Foreign y) rland
show	or	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Loc	cation						10	d. Inside City Limits
28a-f	irect	Maryland Anne	Arundel	An	napo1	is							1 ☐ Yes 2X No
23a or st be n	Funeral Director	10e. Street and Number 2001 Forest	D 100			10f. Zip Cod				10g. Cit	izen of Wha		y?
tems ?	-une	11. Marital Status	12. Was Dece	dent Ever in U.S		Vas Decedent o	401 of Hispanic Ori	gin? (Spe	cify Yes or No-	I	USA 14. Race - A		n Indian,
l', or i	þ	1 Never Married 2 Man	ied Armed For	2 V No		Yes, specify C			Rican, etc.)		Black, V Specify:	white, et B1a	
natura ical E)	letec	3X Widowed 4 ☐ Divorced	Year or Da			ent's Usual Occ					nd of Busine		
powers and 2 per land 20 per land and Mental Hygiene. Important if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	(Specify only higher Elementary/Seconday (0-12) 12th	st grade completed) College (1-		life. DO	ind of work don NOT use retire hool T	red)		7g	Anr		und	el Co.
ed oth	To Be	17. Father's Name (First, Middle, L William Smit)							(First, Middle,	Maiden S	Sumame)		
nd Mer mark imatic		19a. Informant's Name/Relationsh			10h Mailin	a Address (Stre			Marie			Zin Co	ode)
n 27 is n 27 is er trau		James M. Mooney(Son) 42 Parole St. Annapolis, Md. 21401											de)
it of He If item or oth		20a. Method of Disposition 1 ↑ Burial 2 ☐ Cremation	3 Removal from	State 20b. P	Preof Disper emetery, crem	ition (Name of latory or other p			ate	20c. Lo	cation - City	or Tow	n, State
artmen ortant: injury		4 ☐ Donation 5 ☐ Other (S 21. Signature of Funeral Service L	pecify)	Me		1 Park		8-5-			apol		Md.
any once		Zarry A.	Rese Ma	483		muame Ree 21 Wes							1
		23a. Part 1. Enter the disease, or shock, or heart failure. List o	complications that c	aused the death									Approximate nterval Between
ysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	= a Fla	sh P		nary	Ed	emo	1				Onset and Death
xaminer		Sequentially list conditions,	I SC	hem		ardi	omvo	pa	thy			9	years
ansit	xaminer	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	Due to (or as a consequ	ence of):			,					
rsician an e burial-tra	w l	that initiated events resulting in death) Last	Due to (or as a consequ	ience of):								
ing phy e as the	/Med	IF FEMALE:											
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Birth 2 🗌 Feta ant at time of d	l death 3 🗌	Ectopic pregna Other (specify)				2	23d. Date of Month		y Yay Year
gned by se deta	by Pi	Part II. Other significant conditio	ns contributing to de ナゥ ナム	eath but not resi	ulting in the ur	nderlying cause	given in Part I	l.					cause of death?
been si	eted	Failure	10 17	rive	, aac	/ / /							bly 4 Unknown
e has b	duc								24a. Was a autop perfo	sy rmed2	prior death	to comp	y findings available pletion of cause of
tificate tor, pa		25. Was case referred to medical				26.	. Place of Deat	h (Check	1 L Yes	2 No	1 🗆	Yes 2	□ No
his cel	잍	examiner? 1 🗆 Yes 2 🗙 No		npatient 2		3 □ DOA C	Other: 4 🗆 Nu	rsing Hon	ne 5 🗆 Resid	ence 6	Other (S)	pecify)	
h. After t funera	cate:	27. Manner of Death Natural 5 Pending	9	of injury n, Day, Year)	28b. Time of injury	28c. In W	ijury at ork? ☐ Yes 2 ☐		8d. Describe h	ow injury	occurred		
after deat Director: in by the	Certificate:	2 ☐ Accident Investig 3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	ot be 28e. Place	of Injury - At ho g, etc. (Specify)				-	28f. Location (S City or Tow		Number or	Rural R	oute Number,
Funeral Funeral Fited filled	ल	(Check 2 Medical Ex		s of examination	and/or investi-	gation, in my op	oinion, death oc	curred at t	the time, date a	nd place,	and due to t	he cause	e(s) and manner stated.
within To the comple		only one) 3 L Certifying 29b. Signature and title of certifier	Nurse Practioner: T	o the best of my	knowledge, de		t the time, date	and place		. ,	and manner signed (Mo		
		> fland	Bere	2 m	7	D	0029	57	1	07	1/29	/2	010
45		30. Name and address of person w	ho completed calls	of death (Item	23a) (Type, Pr	e fen	se o	wy	, (1)	0 f;	ton,	m	010
State Registra	-	31. Date filed (Month, Day, Year) AUG 03	2010 32. 8	gistrar's Signati	ure A	ends		7	2,0				
		7,000			7								

			for State	of Maryland / De			/lental Hyg		2501.1	
			Registrar 1. Decedent's Name (First, Middle, Last)		Certificate of L	Jeath		Reg. No 2010	25941	
	Physicia		EDITH M.	SMITH			2. Date of Dear	Day Year	3. Time of Death	
	Medic Examin		4a. Facility Name (if not institution, give street and nu		4b. City, Town, o	r Location of Death		4c. County of Death		
. nd	/			lical conto	If Under 1 Year	lisbur	1		mco	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 🕮 F	7. Age (In yrs. last birthd	Months Days	If Under 24 Hrs. Hours Min.	B. Date of Birth APR 29	Year) 918 9. Birt	hplace (State or Foreign RYLAND	
	land show d at	_	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	Location				40.41.34.60.43.3	
	arylan a-f sh ified a	Director	MARYLAND WORCESTER		EYVILLE				10d. Inside City Limits 1 ☐ Yes 2 🗓 No	
	the M or 28	Dir	10e. Street and Number	WIIII	10f. Zip Code		T	10g. Citizen of What Co		
	h with ns 23a nust b	Funeral	8641 WHALEYVILLE ROAD		2187	2		USA		
10	r deat or iten niner r		Armed F	orces?	 Was Decedent of H If Yes, specify Cuba 			14. Race - Amer Black, White		
Maryland 21215-0036	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	ed by	3 🖾 Widowed 4 🗆 Divorced If Yes, G		1 ☐ Yes 2 🏻 No	Specify:		Specify: WH	IITE	
5-0	72 hou "natu edical	Completed	15. Decedent's Education (Specify only highest grade completed	d) (G	ecedent's Usual Occup	during most of work	ing	16b. Kind of Business I	ndustry	
72	vithin i iene. rr than the M	10a. State 10b. County 10c. City, Town or Location 10c. City, Town or Location 10c. City Town								
g	l be filed v lental Hyg rked othe iic event,) Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle, N	Aaiden Surname)	<u> </u>	
yla	should be file n and Mental I 7 is marked o raumatic eve	To	WINDER C.	LAYFIELD		ALICE	M	ITCHELL		
Ma	2 shou lth and 27 is m r traum		19a. Informant's Name/Relationship (Type, Print) JEAN BOZMAN/DAUGHTER					City or Town, State, Zip BURG, MD 21	,	
re,	of Health fitem 27 rother tra		20a. Method of Disposition	20b. Place of D	sposition (Name of crematory or other place			20c. Location - City or		
Baltimore,	Page 1 ment of tant: If it tury or o		1 X Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation ☐ Other (Specify)	II Otate	CEMETERY		/2010	WHALEYVILLE	, MARYLAND	
Bail	permit. Page 1 Department of Important: If i any injury or once.		21. Signature of uveral Selvice Ligens	1	22. Name and Addres		ME CET	DVVIII DE	LAWARE 1997	
			23a. Part T Enter the disease, or complications that	caused the death. Do not					Approximate	
4	nysician/		shock, or heart failure. List only one cause on a limmediate Cause (Final disease or condition	oti Shac	h				Interval Between Onset and Death	
	Medical Examiner		resulting in death) a. Due to	r as a consequence of):						
		Jer	Sequentially list conditions, if any leading to immediate b. Due to	or s a conse uence of	61000					
	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	ute hid	ney In	Jury				
	ate be executed physician and the burial-transit	al Ex	resulting in death) Last Due to	(or as a consequence of):	Λ	(
760	death certificate be executed he attending physician and ed for use as the burial-transi	edical	d. <u>In</u>	eumonia	- 175pm	100				
(687	sath certifica attending ph I for use as th	Physician/Me	Ebb. Was decedent pregnant	itcome of pregnancy	2			23d. Date of deli	very	
Вох	death he atte ed for	sicis		gnant at time of death	3 Ectopic pregnand 5 Other (specify)	y		Month	Day Year	
P.O.	The law requires that the de ate has been signed by the page 2 should be detached	, Phy	Part II. Other significant conditions contributing to	death but not resulting in t	ne underlying cause giv	ren in Part I.	23e. Did tob	pacco use contribute to	the cause of death?	
S, F	uires th	ed by					1 □ Y€	es 2 🛂 3 🗆 Pro	obably 4 🗆 Unknown	
Ö	law requ has bee le 2 shou	Completed					24a. Was ar		opsy findings available ompletion of cause of	
Ř		Com					perforr	med? death?	2 No	
ā	sician: The certificate rector, pag	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:		Othe	ace of Death (Check				
o 	ding Phys h. After this funeral di	e: 10	27. Manner Death 28a. Date		e of 28c. Injury	4 LJ Nursing Ho		ence 6 Other (Specif w injury occurred	y)	
ono	Attending Physician: rr death. ector: After this certific by the funeral director,	ficat	2 Accident Investigation	nth, Day, Year) injui		? Yes 2 🗆 No				
Division of Vital Records,	al or Attend s after death I Director: / d in by the f	Certificate:	4 Homicide determined 28e. Plac	e of Injury - At home, farm, ling, etc. <i>(Specify)</i>	street, factory, office		28f. Location (Str City or Town	reet and Number or Rura , State)	al Route Number,	
۵	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	29a. Certifier 1 Certifying Physician: To the	best of my knowledge, dea	th occured at the time	date and place, an	d due to the caus	se(s) and manner as stat	ed.	
	the Ho hin 24 the Fu nplete	Mec	(Check 2 Medical Examiner: On the batter only one) 3 Certifying Nurse Practioner	of the second second	4 11 11 11				ause(s) and manner stated. stated.	
	S S S S S		29b. Signature and title of certifier	~ Mi	29c. License	number	2	9d. Date signed (Month,	Day, Year)	
	May!		30. Name and address of person who completed cau	se of death (Item 23a) (Type Registrar's Signature	e, Print)	- OT/) C		1101	110	
	70,	_	Ali Saberi, m.p.	PRMC 1	oo E Car	011 St.	Salsbu	ry, MD.	71822	
	Stat Registra	e Ir	31. Date filed (Month, Day, Year) AUG 0 3 2010	Registrar's Signature	back			/ -		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM# 20b, perFH, G906, 87 187 2010, WS

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JOHN THOMAS TYNER, III Jour 24,2010 Year 5:10P Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death
CHARLOTTE HALL 4c, County of Death ST MARY S CHARLOTTE HALL VETERANS HOME 5. Social Security Number If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Funeral 8. Date of Birth 9. Birthplace (State or Foreign Days Hours 1 🔀 M 2 🗆 F 213-46-8675 63 Director Yrs. 9 (Mgnth, Day 5934) 6 WASH, D.C. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director LA PLATA MD. CHARLES 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5017 SKYLARK DRIVE 20646 U.S.A. 12. Was Decedent Ever in U.S.
Armed Forces?
1 X Yes 2 □ No ARMY
If Yes, Give VIETNAM
Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 X Married Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 XNo Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working iffe ONOTUSE returned SUPERVISOR 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) CHARLES CO.GOVT. 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
PHYLLIS WOOD ဂ္ JOHN THOMAS TYNER, JR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code $5017\ SKYLARK\ DR$. LA PLATA , MD . 20646DEBORAH TYNER-SPOUSE Baltimore, August 1 5, 2010 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of 1X Burial 2 ☐ Cremation 3 ☐ Removal from State MD. VETERANS CEM. CHELTENHAM, MD. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee M00479 2. Name and Address of Facilit RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ METASTATIC disease or condition IVER Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Completed by Physician/Medical Examiner Due to for as a consideration of attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Dav Year Pregnant at time of death been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DIABETUS MELLITUS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? completed filled in by the funeral director, æ 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No Other: ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' 2 Accident
3 Suicide
4 Homicide 1 Tes 2 No Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD DOO67788 . 26.10 ML 刀十 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) then . Hall Rel. 29449 C KODALI ENA RAO 2062 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 182010 Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Please Type or Print State of Man		artment of Heal		-	•	•
	_	State Registrar	Cer	tificate of Dear			g. Ng2 0 1 0	25943
Physiciar Medica	al	1. Decedent's Name (First, Middle, Last) William Davis Turner,	Jr.			2. Date of Death	Day Year	3. Time of Death
Examine	er	4a. Facility Name (if not institution, give street and number) 417 Kerwin Road		4b. City, Town, or Local Silve	tion of Death r Spring	J	4c. County of Dea Mont	th gomery
Funeral Director		175-36-8625 1 M 2 □ F	yrs. last birthday) 65 Yrs.	If Under 1 Year If Under 1 Year Hou		8. Date of Birth (Month, Day Y July 29,	ear Co	thplace (State or Foreign untry) onsylvania
show d at	호		c. City, Town or Loc					10d. Inside City Limits
r 28a-f	Funeral Director	M D Montgomery 10e. Street and Number		Silver S	Spring	1.0	g. Citizen of What Co	1 Yes 2 No
is 23a c	neral	417 Kerwin Road		2090	01	1	United Sta	
ter d	ا≲	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 43℃ Noivorced 12. Was Decedent Ever Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates.	1f	Vas Decedent of Hispanion of Yes, specify Cuban, Med The Yes 2 ♣ No Specify Cuban of Specify Res 2 ♣ No Specify Res 2 ♠ No Spe	xican, Puerto R	ify Yes or No- lican, etc.)	14. Race - Ame Black, Whit Specify. Afr A m 6	e, etc.
ithin 72 hou ene. r than "natu the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+	(Give k	lent's Usual Occupation kind of work done during O NOT use retired) Teacher	most of working	g 10	6b. Kind of Business Educatio	
d be filed w Mental Hygi arked othe atic event,	To Be	17. Father's Name (First, Middle, Last) William Davis Turner, Sr.		18. N		(First, Middle, Ma	iden Sumame) rris	
2 shou Ith and 27 is m		19a. Informant's Name/Relationship (Type, Print) William D. Turner III / son		g Address (Street and Nu				
t of Hea t of Hea If item or other	l	20a. Method of Disposition 1 Burial 2 □ Cremation 3 Removal from State	20b. Place of Dispos		Da	ate 20	Oc. Location - City or	Town, State
nit. Pag artment ortant: injury o	ŀ	4 Donation 5 Other (Specify) 21. Signator of Funeral Service Licenses		sh Mem Par			Ambler, P neral Serv	
Dep Imp any any	\Box	I andre Thompson		400 Georgia				
Physician/ Medical		23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	CVI	r the mode of dying, suc	h as cardiac or	respiratory arrest		Approximate Interval Between Onset and Death
Examiner	_	Due to (or as a co	risequence oi).					
ansit ansit	Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	nsequence of):					
	cal Ex	resulting in death) Last Due to (or as a co	nsequence of):					
ificate by g physical as the b		IF FEMALE:						
To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the		23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
quires that the signed by bould be deta	ted by PI	Part II. Other significant conditions contributing to death but n	ot resulting in the ur	nderlying cause given in I	Part I.		cco use contribute to	the cause of death?
The law re icate has be r, page 2 sh							prior to death?	topsy findings available completion of cause of
ystcian s certif directo	lo Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	2 ER/Outpatien	Other:	Death (Check of	1	ce 6 Other (Spec	ifu)
ending Ph eath. or: After thi he funeral	Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day, Ye	28b. Time of	28c. Injury at work? M 1 □ Yes	28	8d. Describe how		,
al or Att		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - building, etc. (S)		et, factory, office	28	8f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
ne Hospita in 24 hours ne Funeral pleted fille	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my Check only one) Certifying Nurse Practioner: To the best	ination and/or investi	igation, in my opinion, dea	ath occurred at the	he time, date and a	place, and due to the	cause(s) and manner stated
With Com		29b. Signature and title of certifier The State of Kertifier Marketine of Kertifier Market	OMF	29c. License numb			Date signed (Monti	
		30. Name and address of person who completed cause of death	(Item 23a) (Type, Pi	5/Ver 5	tand	1096 VI	nn n	1904
State Registra	-	31. Date filed (Month, Day, Year) AUG 02 2010		2	7 13	7	1311 -20	37-7
		/30.	-					

Division or Vital Records, P.O. Box 68760 To the Hospital or Attending I within 24 hours after death.
To the Funeral Director; After

> State Registrar

29c. License number

R100599

UP, Copper Ridge, 710 Obrecht Rd, Sykoville, Naryland

29d. Date signed (Month, Dav. Year)

VNurse Practitioner

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 RUTH В. TULL 1737 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death <u>peraional</u> Medical If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year)
MAR. 31, 1924 Year **Funeral** If Unde 9. Birthplace (State or Foreign 1 □ M 2 🛛 F Months Days Director 86 DELAWARE 222-14-3667 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MARYLAND WORCESTER WHALEYVILLE 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8016 WHALEYVILLE ROAD 21872 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 □ Divorced Specify: WHITE Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည **BREASURE** CLARENCE WILKERSON OLA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8230 DONAWAY ROAD, WHALEYVILLE, MARYLAND 21872 LINDA T. MITCHELL/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) 8/5/2010 DALE CEMETERY WHALEYVILLE, MARYLAND 21. Signature of Funeral Service Lice 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DELAWARE 1997 23a. Part 1. Enter the disease, or conshock, or heart failure. List only polications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician. meu mouring disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** ccystit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of). forector. After this certificate has been signed by the attending physician and d in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Pregnant at time of death Month Dav Year g Unknown g | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy nerformed' Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 🗌 Yes Inpatient 2 🗆 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending work? 1 Yes 2 No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined within 24 hours after To the Funeral Direc City or Town, State) Medical Medical Examiner: On the bast of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in this opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatur 29d. Date signed (Month, Day, Year,

Registrar

State

30. Name and

31. Date filed (Month,

001

of person who completed cause of death (Item 23a) (Type, Print)

3

H005619

			For State		State	of Mary	land / Depa				and M	ental Hy	giene	201	0	05016
			Registrar 1. Decedent's Name (File	rst, Middle, La	st)		Cei	tificate	e or L	eatn	I	2. Date of De	Reg. No	<u>201</u>	U	25946
	Physici Medi		Wertley		,	Е		Ump	h1et	t		Month August	Da	201	ear	3. Time of Death 9:30 P M
	Exami		4a. Facility Name (if not	institution, give	street and nu	umber)				Location o	of Death			. County of		3.30 1
1			Wicomic 5. Social Security Numb	o Nursi						lisbu				Wicom	ico	
	Funeral Director		224-30-392	1 2	ex □ M 2 🖾 F		93 Yrs.	If Under Months	1 Year Days	If Under 2 Hours		8. Date of Bird (Month, Day 1ay 25,	th y, Year)	7	Birthp Count	lace (State or Foreign ry) ginia
	3		Usual Residence of Dec	edent			7.3				I I	lay 25,	191	/	VII	ginia
	ryland I-f show ied at	ctor	10a. State 10b	o. County		10c	. City, Town or Lo	cation							10	Od. Inside City Limits
	or 28a	Dire	MD 1 10e. Street and Number	<u> Vicomic</u>	0		Willards	10f. Zip	Codo							1 Yes 2X No
	with the 23a can st be	Funeral Director	9039 Green	nhranch	Road			Toi. Zip		374 ·			10g. Ci	tizen of Wha		ry?
	Jeath items	Fun	11. Marital Status		12. Was Dec	cedent Ever in	n U.S. 13. \	Vas Deced			gin? (Spec	ify Yes or No- ican, etc.)		USA 14. Race -		an Indian,
38	after o	l by	1 Never Married		Armed F 1 ☐ Yes If Yes, G	2 X No		Yes 2			, Puerto R	ican, etc.)		Black, Specify:	White, e	
215-0036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho , the Medical Examiner must be notified at	Completed	3 🔀 Widowed 4 🗆	. Decedent's E	Year or I		16a. Deced									
25	in 72 h e. tan "n Medi	ld m	(Specify of Elementary/Secondary)	only highest gr	ade complete	d) (1-4 or 5+)	(Give I	ind of world NOT use	k done di		of working	g	16b. K	ind of Busir	ess Indi	ustry
-2	d within ygiene. her tha		12			(1 4 01 04)	Re	cepti	onis	st			C1ot	thing	Man	ufacturer
ZE	uld be filed Mental Hy narked oth	To Be	17. Father's Name (First,	Middle, Last)				_		18. Mothe	r's Name	(First, Middle, i	Maiden .	Surname)		
Maryland 21	19a. Informant's Name/Relationship (Type, Print)							h		Mary			4			Dobbins
	and 2 sh Health aı tem 27 is								Route Number 11ards				ode)			
Baltimore,									e of			ite		ocation - Cit		vn, State
Ē	1 □ Burial 2 文 Cremation 3 □ Removal from State Cremat							-		, I	/2/20	010	Del:	mar,]	Dela	ware
Bal	permit. Departr Importa any inju		21. Signature of Funeral	Service Licens	ée /	Plant	12	Name and			БОС	ınds Fu				
		Н	23a. Part 1. Enter the di	of the	ey f	XAI						Salisb		, MD 2		
	Physician/		Immediate Cause (Final	ure. List only	e cause on e	each line.) Full	. A.T	1 A	, such as c	ardiac or i	respiratory arre	est,			Approximate Interval Between Onset and Death
€	Medical		disease or condition resulting in death)		a	o (or as a cons	sequence of):	VVI		^					+	
	Examiner	١	Sequentially list condition	ins	h. ———											
	sit	nine	Sequentially list condition if any, leading to immed cause. Enter Underlying Cause (Disease or iinjung	iate	Due to	(or as a cons	sequence of):									
	xecute and al-tran	Exa	that initiated events resulting in death) Last		c. Due to	(or as a cons	sequence of);								+	
09	the Hospital or Attending Physician; The law requires that the death certificate be executed hin 24 hours after death. The Funeral Director, After this certificate has been signed by the attending physician and mpleted filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical Examiner		L	d											
6876	tificat ng ph	Med	F FEMALE;													
Box 6	eath certificat attending ph I for use as th	ian/	23b. Was decedent pregi	PLAT PC	23c. If yes, ou	Birth 2 🗌 f	etal death 3						1 2	23d. Date o		
œ.	ne dez / the a ched t	ysic	1 Yes 2 No 9 Unknown		4 ☐ Preg 9 ☐ Unk	gnant at time known	of death 5 □	Other (spe	cify)					Month	D	ay Year
P.O.	requires that the de been signed by the should be detached	Completed by Physician/Me	Part II. Other significant	conditions co	ntributing to	death but not	resulting in the ur	derlying ca	use give	n in Part I.		23e. Did tol	bacco us	se contribut	e to the	cause of death?
of Vital Records,	quires en sig ould b	ted										1 □ Y	es 2[□ No 3 [Proba	bly 4 Nnknown
S	has be	nple										24a. Was a		24b. Were	autops to com	y findings available pletion of cause of
Re	Physician; The lav r this certificate hav ral director, page 2											perform		deat	h?	Ž(No ∗
/ita	siciar certif irecto	∞	25. Was case referred to examiner? 1 ☐ Yes 2 💢 No	L	lospital:	1.			Loui	e of Death	,					`
of\	g Phy er this eral d	e: 10	27. Manner of Death		28a. Date	of injury	ER/Outpatient 28b. Time of		c. Injury a	4 X Nurs		e 5 Reside			oecify)	
o	endin sath. or: Aft he fun	licat	2 Accident	Pending Investigation		nth, Day, Year)	injury	м	work? 1 ☐ Ye	es 2 🗆 N	- 1		,,	00041104		
Division	al or Attending Physis after death. Il Director: After this ed in by the funeral di	Certificate:	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	28e. Place	e of Injury - At ing, etc. (Spec	home, farm, stree	t, factory,	office		28	f. Location (Str	reet and	Number or	Rural R	oute Number,
	spital ours a ours a leral C		29a. Certifier 1 🛭 C	ertifying Phys	oinn. To the h	and of my key	avilades daubles									
	To the Hospital or Atta within 24 hours after de To the Funeral Directo completed filled in by th	Medical	Uneck ZLIM	edicai Examir	i er : On the bas	sis of examina	owledge, death oc tion and/or investion my knowledge, de	ation in my	/ opinion	death occi	urrad at the	a time data an	d place	and due to t	ha aarraa	e(s) and manner stated.
	To the within 2 To the comple		29b. Signature and trile of		/				icense n		ina piace, e	$\overline{}$		signed (Mo		
	\ \		1/1/10	Um	la	11) 6	056	5		8	7/2/1	0	
	WW	3	0. Name and address of						_		_					
	Stat	3	Mahesha 1. Date filed (Month, Day	Thimma	rayapp		910 Ea	sterr	shor	e Dr	Sa1	isbury	MD	21804		
	Registra	r	1. Date filed (Month, Day AUG	0 3 201	UZ	Registrar's Sig	nature for	read								

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 23a Part I Line a per Phy. 08/03/10 Carroll Co., will state of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Thomas D. Weible, Sr. Month Day Medical <u>Auqus</u>t 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Westminster Carroll Social Security Number Funeral 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Months Days Hours (Month, Day, Year) 288-18-2255 87 Yrs Director 14 1923 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits ms 23a or 28a-f s must be notified Maryland Carroll Hampstead 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 400 Dove Lane United States 21074 death \ "natural", or items idical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in LLS 14. Race - American Indian, Armed Forces?

1 X Yes 2 No 1943-Black, White, etc. 1 X Yes If Yes, Give 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 x No Specify. 1945 white 3 Divorced 4 Divorced Specify: Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) salesman tire company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James O. Weible Clara Royer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bervl Weible - wife 400 Dove Lane Hampstead, Maryland 21074 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) August 3, 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 X Removal from State Bloomfield Cemetery New Bloomfield, PA 4 ☐ Donation 5 ☐ Other (Specify) 2010 21. Signature of Funeral Service License 22. Name and Address of Facility Eline Funeral Home M01072 934 South Main Street Hampstead, Maryland 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ SHD (Atherosclerosis Heart Disease) disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) and -transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical certificate be Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Vear 4 Pregnant g Unknown P.O. þ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed certificate 2 🗌 No 1 Tes Yes 2 No Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 Residence 6 Other (Specify) HDS.DICE Division of 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Pleathin 24 hours after death.

To the Funeral Director: After the completed filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pendina 2 Accident
3 Suicide
4 Homicide 1 Tes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) D0061755 8/2/10 WJL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 HEMALATHA NAGANNA 700A POOLE WESTMINSTER, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar A. park

Patient known as Malter Norris Williams

				Please						ure All Copie	_	jible.	
			For State Registrar		State of N	naryian		artment of tificate of		and Mental Hy	rgiene Reg. No.20	110	25948
	Physicia Medi		1. Decedent's Name Walter	(First, Middle, La Norris	williams					2. Date of De Month		Year 2010	3. Time of Death
đ	Examir				e street and number)			4b. City, Town,	or Location		4c. County		
	Funeral Director		SINAL HOS 5. Social Security Nu 217-01-54	38 6. s	F 6ALTIM Sex 1 XM 2 F 9	ge (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under		th 0, 1919	9. Birthpla	ace (State or Foreign ry)
	Maryland :8a-f show rtified at	rector	Usual Residence of	10b County Carrol	.1		y, Town or Loc tminst					10	0d. Inside City Limits
	h with the l ns 23a or 2 nust be no	Funeral Director	10e. Street and Num					10f. Zip Code 21157			10g. Citizen of U.S.A.		ry?
9800	2 should be filed within 72 hours after death with the Maryland th and Mental Hyglene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at		11. Marital Status 1 Never Marrie 3 Widowed 4		12. Was Decedent Armed Forces 1 Yes 2 If Yes, Give Year or Dates.)	41-	Vas Decedent of I f Yes, specify Cub ☐ Yes 2 🗽 No	an, Mexicar	igin? (Specify Yes or No- n, Puerto Rican, etc.) :	Bla	ce - America ck, White, et :: Whit	tc.
21215-0036	ithin 72 ho ene. r than "nat rhe Medica	Completed by	(Special Special 15. Decedent's cify only highest g anday (0-12)		5+)	(Give I life. D	lent's Usual Occu kind of work done O NOT use retired Welder	during mos	t of working	16b. Kind of B		,	
land 2	I be filed w lental Hygi rked other tic event, t	To Be	17. Father's Name (F Carroll E	First, Middle, Last) phraim W	/illiams		DOC	NETGEL	18 Moth	er's Name (First Middle ra Virginia			π ω.
, Maryland	and 2 should be Health and Ment tem 27 is marked tther traumatic e		19a. Informant's Nai Gloria L.				19b. Mailin 559	g Address (Street Sulliva	and Number	er or Rural Route Numbe , Westminst	er, City or Town, S er, MD		ode)
Baltimore,	Page 1 nent of ant: If it		4 Donation	Cremation 3 5 Other (Spec		, I c	emetery, cren	sition (Name of natory or other pla ek Cemet	ery {	Date 8/3/2010	20c. Location	•	vn, State
Ball	permit. Departr Importa any inju		21. Signatur of Fun	21-	5		14	12 Washi	ngton	^{by} Pritts Fun Rd., Westm	inster,		
	mysician/ Medical Examiner		23a. Part 1 Enter the shock, or heart Immediate Cause (F disease or condition resulting in death)	t failure. List only inal	one cause on each lir	ie.		the mode of dying		cardiac or respiratory ar	rest,	1	Approximate Interval Between Onset and Death
0	executed an and rrial-transit	cal Examiner	Sequentially list con if any, leading to imicals English and Cause (Disease or ii that initiated events resulting in death) L	mediate yins njury	b. Due to (or as					_	_		
	that the death certificate be ted by the attending physici detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent r in the past 12 m 1 Yes 2 9 Unknown	nonths?	23c. If yes, outcome	2 🔲 Feta at time of c	l death 3	Ectopic pregnan Other (specify)	су			ate of delivery	y Day Year
ds, P.O	sign sign		Part II. Other signific		contributing to death	but not res	ulting in the u	nderlying cause g	iven in Part		obacco use cont Yes 2 No		cause of death?
Division of Vital Records, P.O.	sician: Tre law equi s certificat⊩ has treen lirector, page 2 snould	Completed by	25. Was case referre	d to modical	T						psy ormed2	prior to comp death?	sy findings available pletion of cause of
Vita	ysicial is certi directo	To Be	examiner?		Hospital:	tient 2 🗆	ER/Outpatien	Oth	er:	th (Check only one) ursing Home 5 Resi	dence 6 □ Oth	er (Specify)	
ion of	To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director. After this certifica completed filled in by the funeral director,	Certificate:	27. Manner of Death Natural 2 Accident 3 Suicide	5 Pending Investigation 6 Could not it	20	ay, Year)	28b. Time of injury		y at	28d. Describe	now injury occurr		
Divis	spital or At ours after o eral Direct filled in by		4 Homicide	determined	building, et	c. (Specify,)	et, factory, office	data and	28f. Location (S City or Tov place, and due to the ca			
	To the Hos within 24 h To the Fun completed	Medical	(Check 2	☐ Medical Exam ☐ Certifying Nu	niner: On the basis of or rse Practioner: To the	examination best of my	and/or invest knowledge, d	gation, in my opini eath occurred at th	on, death och ne time, date	ccurred at the time, date a and place, and due to the	and place, and du	e to the caus anner as state	se(s) and manner stated ed.
	WJZ		* W	18				29c. Licens	→ 580	149	7/29/	2010	
10	OTIVA		Paresh &	shah MD	completed cause of c	nearn (Item	True Y	d, Ste S	35,	Balt., MD	21208		
	Stat Registra		31. Date filed (Month,	Day, Year)	32. Registr	rar's Signat	A. A	ake		Balt., MD			
DHM	H 17 Rev 7/20	09											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25949 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Month Year 534 AM bert Martin ľC /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Westminster Carroll If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 → M 2 □ F 215-24-6100 Director North Carolina 1928 Nov. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ind Medical Examinar mant to inclined at any Injury or other traumatic event. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Carroll Reisterstown 1 ☐Yes 2X No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3542 Lawndale Road, East 21136 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Yo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: white Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) tractor-trailer driver overland transport 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sydney Jackson Wyatt Lucy May Ayers 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Wyatt / wife Reisterstown, MD 21136 3542 Lawndale Road, East 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Evergreen Mem. Gdns. August 2, Finksburg, Maryland 4 Donation 5 Dother (Specify) 2010 21. Signatur of Funeral Service Liee 22. Name and Address of Facility Eline Funeral Home Thank 934 South Main Street Hampstead, Maryland 21074 Senumer 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Non Small Cell **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine Due to (or as a consequence or) if any local g to infine de cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ tonknown Completed anar discare 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 PNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlah-transit hed by the attending physician and detached for use as the burial-tran Medical

Division of Vital Records, P.O. Box 68760.

Baltimore, Maryland 21215-0036

WJL

1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29a. Certifier

(Check only one)

29c. License number 03950241 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

East Main Sweet, westminster MB 21157 Hosain 41 31. Date filed (Month, Day, Year)

State Registrar

AUG 02

32. Pagistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 25950 State of Maryland / Department of Health and Mental Hygiene 2010 state
Registrar Amend#7perfuneralhome8/5/10 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Theresa M Ward 2:00A M Medical 2010 0.2 Angust 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4778 Jaybird Ct Waldorf Charles If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 9. Birthplace (State or Foreign Days Country)
NY 1 M 2 1 F 2/10/1918 91 Director 94 Yrs 119-01-3277 Usual Residence of Decedent Zi is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director txXYes 2 No MD Charles Waldorf 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 4778 Jaybird Ct. 20601 US 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed 3 ☑ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) id Mental Hygiene. marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Home Maker Home Maker Be 17. Father's Name (First, Middle, Last) permit, Page 1 and 2 should be file
Department of Health and Mental h
Important: If item 27 is marked on
any injury or other trainmant 18. Mother's Name (First, Middle, Maiden Surname) ပ Peter Chico Anna Stallone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4778 Jaybird Ct. Waldorf, MD 20601 <u>Gary Ward/Son</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lawn Cemetery 8/9/2010 Buffalo, NY Signature of Fymeral Service Lice 22. Name and Address of Facility Huntt Funeral Home 3035 Old Washington Rd, Waldorf, MD 20601 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician, Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examiner Dusito (or se a consequence or) if any, leading to immediate cause. Enter Underlying attending physician and for use as the bunal-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day ☐ Pregnant at time of death☐ Unknown 1 Yes 2 D the signed by the detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CHRONIC KENAL 1 ☐ Yes 2 XXNo 3 ☐ Probably 4 ☐ Unknown Completed THY DERTENJION 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has bage 2 s autopsy performed? Yes 2 No certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 **1**00 ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 1 Residence 6 ☐ Other (Specify) this Director: After this in by the funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending Accident
Suicide Investigation
6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined hin 24 hours aft the Funeral Di npleted filled ir Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signature and title of certifier 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 50 POST OFFICE ED ATEL 31. Date filed (Month, Day, Year) Registrar's Signature AUG 0 4 2010

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend#8perfuneral8/9/10ccdobbb Certificate of Death Reg. No. 1 - For State 25951 Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Audust 2. ^D2'010 Ethel Edna Wilson 09:30 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Genesis of La Plata La Plata Charles Funeral Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month)Day, 9. Birthplace (State or Foreign 1 M 2 X F Months Days Hours Min West Virginia Director 94 234-68-8404 916 June 6. Usual Residence of Decedent show 10b. County at 10a. State filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director must be notified 28a-f 1 Tes 2XX No Maryland | Prince Georges Brandywine 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 10505 Cedarville Road # 4-4 20613 USA ral", or items 2 Examiner mus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. 1 Never Married 2 Married ð Maryland 21215-0036 1 ☐ Yes XX No Specify: If Yes, Give 3 X Widowed 4 □ Divorced "natural" Specify: White Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Home Maker 8th Own Home Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Perry Asbury Vadie Mc Cov 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1756 Tulip Avenue, Forestville, MD. 20747 Linda G. Williams/ Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State CedaryiTTe Assembly 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 6, 2010 Brandywine, MD. Aug. 21. Signature of Funeral Service Livenses 22. Name and Address of Facility Huntt Funeral Home 3035 Old Washington Rd. Waldorf, MD. 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ CVA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Atrial ribellation Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as Tronsequence of) that the death certificate be executed Demention sician and burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Ectopic pregnancy Month Dav Year Pregnant at time of death Other (specify) 9 Unknown 9 Unknown Records, P.O. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 Yes 2 No Yes 2 No director, of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this filled in by the funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 27. Manner of Death 28b. Time of : After t Certificate: Natural injury 5 Pending Division Accident Suicide 2 🗌 No Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I 3 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

2007 Tridoenater Colony Dr. Svite IA, Annapolis

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KAUR

KIRANDEEP
31. Date filed (Month, Day, Year)

AUG 0 4 2010

			For	State of	Marylar	nd / Depa	artment of	Health	and M	lental Hy	giene	010	05050
			State Registrar			Cer	tificate of	Death			Reg. No.	010	25952
Н	Physicia	an/	Decedent's Name (First, Midd							2. Date of De Month		Year	3. Time of Death
	Medi	cal	Mike Whita							August	7, 20	010	7:30 p M
	Exami	ner	4a. Facility Name (if not institutio		er)		4b. City, Town,					ounty of Death	
	Funeral	-	26331 Meadow 5. Social Security Number		Age (In yrs.	last birthday)	Mechan If Under 1 Year		LLLe er 24 Hrs.	8. Date of Bir		t. Mary	S place (State or Foreign
	Director		227-54-8624	1 📉M 2 🗆 F	69	Yrs.	Months Days			July 3	y, Year)	1 West	virginia Virginia
	d tow]_	Usual Residence of Decedent 10a. State 10b. County		140.00						,		7 - 2 / 2 - 2 - 2
	arylan a-f sh fied a	읂				ty, Town or Lo						111	10d. Inside City Limits
	or 28	ä	Maryland St.	Mary's	M	lechani	10f. Zip Code				10 0111		1 Yes 2 No
	with the 23a ust be	eral	26331 Meadow V	Wood Dr.			20659				US.	en of What Cour Δ	ntry?
	teath tems er mu	Funeral Director	11. Marital Status	12. Was Decede			Vas Decedent of I	lispanic Or	rigin? (Spec	cify Yes or No-		. Race - Americ	can Indian.
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 🗶 Ma 3 ☐ Widowed 4 ☐ Divorce	If Van Oire	□ No		Yes, specify Cub			ican, etc.)		Black, White, becify: Whi	etc.
2-0	natur dical	Completed		ent's Education	J.	16a. Deced	ent's Usual Occu	pation	_		16b, Kind	of Business Inc	dustry
21	nin 72 ne. than "	l E	Elementary/Seconday (0-12)	College (1-4	or 5+)		ind of work done NOT use retired		st of workin	g			
121	d with tygier ther t	BeC	47 E-11 1 M			Pro	ject En	ginee	<u>r</u>		Dept.	of Na	vy
Maryland	oe file antal P ced o	10	17. Father's Name (First, Middle, Louie Douglas	,				I		(First, Middle,		name)	
Z	ould lo		19a. Informant's Name/Relations			405 44-15-	- 11/2 /0/2			nie Ta			
Š	d 2 shalth an 27 is	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 26331 Meadow Wood Dr., Mechanicsville,											
Je,	1 and of Hear		20a. Method of Disposition		20b. F	Place of Dispos	sition (Name of			ate		tion - City or To	
<u>ii</u>	Page ment ant: It		1 ☐ Burial 2 🔀 Cremation 4 ☐ Donation 5 ☐ Other (Bri		atory or other pla lEcho1s(08/1	1/2010	Char1	Lotte Ha	all,MD
Baltimore,	permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau		21. Signatur, of Funeral Service	Licensee	7	22.	Name and Addre	ss of Facili	ity Brin	sfield	-Echol	s F.H.	, P.A.
	22200		23a. Part 1. Enter the disease, or	fill It	and the deat							Hall,	MD 20622
ы		3 1	shock, or heart failure. List	only one cause on each	line.			ig, such as	s cardiac or	respiratory ari	rest,		Approximate Interval Between Onset and Death
	Medical		disease or condition resulting in death)	a	Body :	Dementi	la						Onset and Death
-	Examiner			Duc 10 (6)	ao a consequ	zerice oi).							
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or a	as a consequ	ience of):							
	cuted	Examiner	Cause (Disease or linjury that initiated events	c									
_	death certificate be executed ne attending physician and ed for use as the burial-transit	ial E	resulting in death) Last	Due to (or a	as a consequ	ience of):							
760	cate to physicate to the control of	ledical		d									
88	ath certific attending p	N/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor							224	d. Date of delive	in.
Box 68	death e atte	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live Birt 4 Pregnar	t at time of d		Ectopic pregnand Other (specify)	cy			230		Day Year
P.O.	that the des	Phy	9 Unknown	9 🗆 Unknow									
о. С	v requires that s been signed t should be det	by	Part II. Other significant condition	ons contributing to deat	n but not resi	ulting in the un	derlying cause gi	ven in Part	1.		- /	/	e cause of death?
ğ	requir been s hould	etec								1 🗆 ነ			ably 4 Unknown
Division of Vital Records,	2 2 2	Completed									sy med?	prior to con death?	sy findings available npletion of cause of
a	ician; The certificate rector, pag		25. Was case referred to medical examiner?				26. PI	ace of Dea	nth (Check o	1 Yes	2 La No	1 Yes	2 ₩ No
₹	hysic his ce I direc	일	1 Yes 2 No	Hospital:	atient 2 🗌	ER/Outpatient	Oth	Dr:			ence 6 🗆	Other (Specify)	
o	ing P	ate:	27. Man√r of Death 1 Natural 5 □ Pendin	28a. Date of in (Month, L		28b. Time of injury	28c. Injury	/ at		d. Describe h			
Sior	ttend death stor: A the f	Certificate:	2 Accident Investig	gation not be				Yes 2] No		_		
Six i	al or A s after I Direct d in by		4 ☐ Homicide determ		njury - At noi etc. (Spec <i>ify)</i>		t, factory, office		28	3f. Location (Si City or Town		ımber or Rural I	Route Number,
_	lospit hour unera	Medical	29a. Certifier 1 Certifying (Check 2 Medical E	Physician: To the best	of my knowle	edge, death oc	cured at the time	date and	place, and	due to the cau	ise(s) and m	anner as stated	i.
3	In the Nospital or Attending Physician; The kawithin 24 hours after death. To the Funeral Director. After this certificate he completed filled in by the funeral director, page		(Cilect Z I Medical E	Nurse Practioner: To the	r examination	and/or investig	ath occurred at the	e time, date	collirred at th	and due to the	nd place, and cause(s) and	d due to the caused manner as sta	se(s) and manner stated. ted.
	2 ≥ 5 8		Zeb. Signature and title of certifier		endir	25-	29c. License			2		gned (Month, D	ay, Year)
		-	30. Name and address of person v			4		55682			08/0	09/2010	
؎			Thomas M. Wi				y St.,	Leona	rdtow	n, MD	20650		
	Stat	_	31. Date filed (Month, Day, Year)	32. Fegis	1 0: 1								
H.	Registra	r	AUG 11	2010 Dece	un p	g. Ja	New _						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10-05892 State of Maryland / Department of Health and Mental Hygiene Timothy J Williams 2010 1-For Statemended item#12, WCHD, SLU Certificate of Death 13.10 Reg. No 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ 2046 hrs August 4, 2010 **Medical Examiner** c. County of Death 4b. City, Town, or Location of Death Facility Name (if not institution, give street and number) Crisfield Somerset McCready Hospital 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYY) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min Months Davs Hours Director 1 M 2 F Country) Yrs Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No 28a-f show or items 23a or 28a-f sho must be notified at once. death with the Maryland Director 10g. Citizen of What Country 10e Street and Number 14. Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Marital Status 12 Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces Never Married 2 Yes Yes 2 No specify: imore, MD 21215-0036
Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or If Yes, Give Year Specify: 3 Widowed Divorced ě 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) event, the Medical 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ance (Street and Number or Rural Route Numbe City or Town, State, Z/p Code) 19b. Mailing Address 19a. Informant's Name/Relationship (Type, Print) other traumatic 20c. Location - City or Town, State 20b. Place of Disposition (Name of ce Date 20a Method of Disposition crematory or other place) 2 Cremation 3 Removal from State Burial Veterans Cemetery Donation 5 Other Specify 5 nature of Funeral Service Licenses 22 Name and Address of Facility Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and /Medical Death Exacerbation of chronic obstructive pulmonary disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): complicated by cocaine use Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical X UNPENDED physician the burial -AMEN252,27,per ME g910 12/7/10 TT Box 68760, 23d Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 3b. Was decedent pregnant in the Month Day Year Ectopic pregnancy Live birth Fetal death use as past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. O. ≥ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of page 2 s performed' ✓ Yes 2 1 V Yes 25 Be this ဥ 27.

To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, After Director: 24 hours after death

Nas case refer	red to medical				26.Plac	of Death (Check	only one)			
examiner?		Hospital: 1 Inpa	ent 2	ER/Outpatient 3	DOA	Other Nursi	ing Home 5	Residenc		
Manner of Deal	th	28a. Date of Ir		28b. Time of Injury	28c. Inju	ıry at Work?	28d. Describ	e how injury	occurred	
Natural	5 Pending		Year)		1	Yes 2 No				
Accident	Investiga		mirana At h	nome, farm, street, factor	one office	building etc	28f Location	(Street and	Number or Rural R	oute Num
Suicide	6 Could no	ot be	rijury - At i	iome, iam, sueet, iact	biy, onice	bulluling, etc.	or Town		114411120101114	
Homicide	determin	ed (Specify)								
Certifier 1	Certifying Physi	cian: To the best of	ny knowled	ige, death occurred at	the time, d	ate and place, an	d due to the ca	use(s) and	manner as stated.	
2 🗸	Medical Examin	er:On the basis of ex	amination a	and/or investigation, in	my opinio	n, death occurred	at the time, da	e and place	e, and due to the cau	ıse(s)

30. Name and address of person who completed cause of death (Item 23a)

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

ber, City

29d. Date signed (Month, Day, Year)

August 7, 2010

State Registra

Certification

2

3

29a (Che one) Medical

29b. Signature and title of certifier

Melissa Brassell, MD

OCME

31. Date filed (Month AUG 1

egistrar's Signatur 32

Assistant Medical Examiner

within 2 To the 1

			1 - State Registrar	State of M	aryland / Depa	artment of He rtificate of D				010	25954
	Physici /Medi		1. Decedent's Name (First, Middle, John	Last) Wesl	ey	Young		2. Date of De Month August		010 ^{Year}	3. Time of Death 7:45 am M
1	Examir			are 6. Sex 7. A	ge (In yrs. last birthday)			8. Date of Bir	Wa	unty of Death ashingt 9. Birthp	place (State or Foreign
1.5	Director		233–68–4013 Usual Residence of Decedent 10a. State 10b. County	XX M 2□ F	67 Yrs.		TIOUIS IVIIII.	5/11/1	943		Virginia Od. Inside City Limits
	or 28a-f she e notified a	Director	WV Berk 10e. Street and Number		Falling	Waters 10f. Zip Code			10g. Citizen	of What Cour	*
5-0036	The flat and Montal Hygiene. The flat and Montal Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Marrie Widowed 4 Divorced	12. Was Decedent Armed Forces	No	25419 Was Decedent of Hisp If Yes, specify Cuban,		ecify Yes or No Rican, etc.)		U.S.A. Race - Americ Black, White, pecify: Wh	can Indian,
2121	al Hygiene. other than "natur	Completed by	15. Decedent (Specify only highest Elementary/Secondary (0-12) 12	grade completed) College (1-4or	(Give	dent's Usual Occupati kind of work done dur DO NOT use retired) lachinist	ring most of work		Truck		acturing
land	and Mental H s marked ott umatic even	To Be	17. Father's Name (First, Middle, L Frank Lu		Young	1	8. Mother's Name		, Maiden Sui		.nk
$\mathbf{\Sigma}$	Health and M tem 27 is mar other traumati	-	19a. Informant's Name/Relationsh Carol A. Downs	p (Type. Print)	19b. Mailii	ng Address (Street and	d Number or Run	al Route Numb		own, State, Zip	Code)
Baltimore,	rtment or		20a. Method of Disposition 1 Service 2 Cremation 4 Donation 5 Other (Sp. 21. Screen of Funeral Service L.	ecify)	Greenway	cemetery	8/10		Berkel		ings, WV
Ba	Impo any ir		21. Matter of the late of vice) (Name and Address Helsley—Jor 15 Union St					411–1855
ě,	hysician /Medical xaminer		23a. Part1. Enter the disease, or of shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death)	or respiratory a	rrest,		Approximate Interval Between Onset and Death				
68760,40	physician and the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	a consequence of):						
l Records, P.O. Box 68 The law requires that the death certifies		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3	Ectopic pregnancy Other (specify)			23d.	. Date of delive	ery Day Year
ords, F	been signed by the a	þ	Part II. Other significant condition	ns contributing to death be					tobacco use Yes 2□ N		he cause of death? pably 4 2 Unknown
		Completed	Insperten	ian More	lipilen.			24a. Was auto perfo 1□ Yes		prior to co death?	opsy findings available mpletion of cause of 2 No
or Vital	is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:	ent 2 ☐ ER/Outpatier	Other	26. Place of Death			30.1 (D. 11	
ISION	death. ctor: After y the fune	Certification: To	27. Manner of Death 1	28a. Date of Inju (Month, Date of Inju- tion at be 28e. Place of Inju-	ury 28b. Time of	f 28c. Injury a Work? M 1 Ye	s 2 No	28d. Describe	how injury or Street and N	ccurred	y) al Route Number,
Di Hospital or	within 24 hours after To the Funeral Dire completely filled in b	edical Cert	29a. Certifier 1 ☐ Certifying (Check only 2 ☐ Medical E	Physician: To the best xaminer: On the basis of	of my knowledge, deatl	n occurred at the time, vestigation, in my opir	, date and place, nion, death occur	and due to the	cause(s) an	d manner as s	stated. o the cause(s)
To the	within 2 To the comple	Med	29b. Signature and title of certifier	and manner st	ated.	29c. License n				igned (Month,	
)	+1		30. Name and address of person w		death (Item 23a) (Type,	Print)	MAG				
	Sta Registr	_	31. Date filed (Month, Day, Year) AUG 18 2010	32. Registr	rar's Signature	,					

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Miriam Zeevi July 24. 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 198 Halpine Road #1177 Rockville Montgomery If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 12/26/1953 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex Days 1 □ M 2 🖾 F 56 220-19-6354 Israel Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No Maryland Montgomery Rockville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 198 Halpine Road #1177 20852 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 € No 1 ☐ Yes 2 ☐ KNo Specify White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Jewelry Making Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Erna Aberman Moshe Kritz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 198 Halpine Rd, #1177, Rockville, Maryland Tami Zeezi, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garden of Remembrance
Memorial Park

Date
20c. Location - City or Town, State
Clarksburg, Maryland 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Edward Sagel Funeral Direction, Inc. 21. Signature of Funeral Service Licensee MO1477 1091 Rockville Pike, Rockville, Maryland 23 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) AMYOTROPHIC LATERAL SCIERESIS 5425 Due to (or as a consequence of): Sequentially list conditions, it am, adding a financial cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for all a consequence of Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 □ Yes 2 🗷 Io 9 Hlnknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performed' 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aresidence 6 Other (Specify) 1☐Yes 2⊠No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

and burial-tran signed by the attending physician I be detached for use as the burial The law requires that Division of Vital Records, peen has page 2 After this certificate I funeral director, page To the Hospital or Attending Physician: death. within 24 hours after death

To the Funeral Director:
completely filled in by the

Physician

/Medical

Examiner

Funeral

Director

show

the

Baltimore, Maryland 21215-0036

Director

þ

Completed

d other than "natural", or items 23a or 28a-f sho event, the Medical Exeminating must be notified at

permit. Pages 1 and 2 should be filed a Department of Health and Mental Hygid Important: If item 27 Is marked other any Injury or other traumatic event, III

Physician /Medical

Examiner

Examiner

Physician/Medical

Completed

Be

မ

Certification:

Medical

31. Date filed (Month, Day, Year) --State Registrar

29b. Signature and time of certifier

JUITE 5072 BAND. Mg 21287 IHOPC GOI NORTH CARCUNE 57 82. Registrar's Signature

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

00034831

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 1State of Maryland (Department of Health and Mental Hygiene 2010 25956

	1- For State Registrar Certificate of Death Reg. No.									
Physici Medical Exam		1. Decedent's Name (First, Middle, Last)	amal Eria		Hia		2. Date of Death Month August 9, 2	Day Year 2010	3. Time of Death 0339 hrs	
		4a. Facility Name (if not institution, give 7753 Baltimore Annapolis I			City, Town, or I Glen Burnie	Location of Death	ו	4c. County of Death Anne Arundel		
Funeral Director		5. Social Security Number 6. Sex	/ _		If Under 1 Year Months Days		_	1962 Foreig		
Maryland 28a-f show any d. at once.	tor	Usual Residence of Decedent 10a. State 10b. County A A	10c. City,	Town or Location	Burr	ne			10d. Inside City Limits 1 Ves 2 No	
death with the Maryland or items 23a or 28a-f sho must be notified at once	l Direc	26 Hollowa	V Street	- 1	Of. Zip Code	060	10	ng. Citizen of What Cour)+	
	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No 1f Yes, Give Year or Dates:		specify Cuban,	Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Amen White, etc. Specify:	can Indian, Black,	
nore, MD 21215-0036 ages I and 2 should be filed within 72 hours afte nt of Health and Mental Hygiene. ut: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner	Completed t	15. Decedent's Education (Specify only Elementary/Secondary (0-12)	y highest grade completed) College (1-4 or 5+)	ai		on (Give kind of v DO NOT use reti		16b. Kind of Business/	en Store	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	17. Father's Name (First, Middle, Last)	unk				(First, Middle, M	· 4	ne	
ore, MD 21 es 1 and 2 should of Health and Mes If item 27 is man	T ₀	19a. Informant's Name/Relationship (Tyl	d-Priest	19b. Mailing Ad 8340	Woo	dwar	dSt,	Savage	MD	
MOre Pages 1 nent of H ant: If i		1 Burial 2 Cremation 3 4 Donation 5 Other Specify 21. Signature of Funeral Service ons	Removal from State	ematory or other		10 8/	Date / 11 / 2010	20c. Location - City or	rown, State	
Balti permit. Departn Import	9 13	Alle Du	el	1022	20 Gu	ilford	Rd.	HUNGIAL JESSUP, M	10 20794	
Physician /Medical Examiner	b	23a. Part I. Enter the disease, or complice failure. List only one cause on each Immediate Cause (Final disease a. Sor condition resulting in death)	st, shock, or heart	Approximate Interval Between Onset and Death						
	-	Sequentially list conditions, b	ue to (or as a consequence of): ue to (or as a consequence of):							
	amin	cause. Enter Underlying Cause (Disease or injury that initiated	ue to (or as a consequence of):							
ecuted and transit	al Exa	d								
760, icate be execut physician and the burial - trait	/Medical	2.400-04-2	AMENDED#8 per fl		3/02/20	11dhb				
18760, rifficate be mg physic as the burn	W/u	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnation 1 Live birth	ancy 2 Fetal o	leath 3	Ectopic pregna	ncy	23d. Date of delivery Month D	ay Year	
Box 687 death certification attending of for use as the	Physiciar	1 Yes 2 No 9 Unknown	4 Pregnant at time of deat 9 Unknown	th	(Specify)					
P.O. Bost that the degree by the detached f		Part II. Other significant conditions		sulting in the unde	rlying cause giv	ven in Part I.	23e. Did tob	acco use contribute to t	he cause of death?	
S, P.C uires that n signed I	ed by							2 ✓ No 3 Prob		
of Vital Records, ng Physician: The law require this certificate has been simeral director, page 2 should be	Completed			-			24a. Was ar autops perform	y prior to co	opsy findings available ompletion of cause of	
tal Rection: The certificate ector, page	5						1 ✓ Yes 2		s 2 No	
/ital sicians is certi	Be	25. Was case referred to medical examiner?	spital: 1 Inpatient 2 E	R/Outpatient 3		of Death (Check of Death (Chec		tesidence 6 🗸 Other:	Scene	
of V ing Phy After th uneral c	2	1 Yes 2 No	28a. Date of Injury 2	28b. Time of Injury		at Work?	28d. Describe ho	ow injury occurred		
ivision or Attendi after death. Director: Jin by the fi	atio	Natural 5 Pending Accident Investigation		0330 hrs		s 2 No	Subject shot			
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and aredy filled in by the funeral director, page 2 should be detached for use as the burial - trans	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom (Specify) Convenience		ictory, office bui	-	or Town, Sta	reet and Number or Rur ite) Annapolis Blvd., Gle		
Divi To the Hospital or within 24 hours after To the Funeral Dir	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: C	n: To the best of my knowledge on the basis of examination and	e, death occurred		e and place, and	due to the cause	(s) and manner as state	d.	
FSES	Me	29b. Signature and title of certifier	0/1/1	100	29c. License O.C.M			29d. Date signed (Mon	th, Day, Year)	
	ŀ	30. Name and address of person who con	mpleted cause of death (Item 2	(3a)	J					
·		Victor Weedn MD JD Ass	istant Medical Examine	er 111 Pen	n Street, Ba	Itimore, MD	21201	·		
St Regist		31. Date filed (Month, Day, Year) AUG 1 9 2010	32/Registrar's Signature	park						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Frances Allen Armstrong August 18 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Stella Maris Timonium Baltimore 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2X-XF Months Days Hours Min. January 5, 216-22-7154 81 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location death with the Maryland 10d. Inside City Limits Director or 28a-f s notified Baltimore Timonium 1 Yes 2XX No Marylan**(**1 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be Funeral 21093 2300 Dulaney Valley UnitedStates Rd 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. δ 1 Never Married 2 Married within 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2XX No Specify. 3XX Widowed 4 ☐ Divorced Completed Specify: white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) actress/model modeling ortant: If item 27 is marked other injury or other traumatic event, t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Claris Allen Mabel Murray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 824 Cinammon RidgePlace Jacqueline Armstrong/Dtr-i , Apt. F Department of Healt Important: If item 2 any injury or other t Baltimore, Lawr Cockeysville, 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley M.G. 8/23/10 Timonium, Maryland 22. Name and Address of Facility John O. Mitchell IV, Funeral Services of Dulaney Valley, P.A. 200 E. Padonia Rd. Timonium, MD 21003 21. Signature of Funeral Service License John O. Mitchell 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode or dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ eass disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to for as a consequence of Exami ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ₹ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe after death.

Director: After this certificate 2XI No 1 🗌 Yes Division of Vital Hospital or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 1 🗌 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Matural Natural 5 Pending 1 🔲 Yes 2 🗌 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) To the Hospital within 24 hours a To the Funeral L Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certif 29c. License numbe 18 2010 and address of person who completed cause of death (I em 23a) (Type, Print) WRIGHTERNESTINE M.D.DULANEY VALLEY ROAD TIMONIUM MD32. Registrar's Signature State

DHMH 17 Rev 7/2009

ARMSTRONG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Thourrahium Month 130am Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Rock Glenn Nursing & Rehab. Baltimore NA Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
0 7 - 0 3 - 4 3 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 🛛 M 2 🗆 F Min. Country) Director 214-38-3558 Usual Residence of Decedent 28a-f shov 10a. State 10b. County r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore XX Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10 North Rock Glen Road 21229 USA death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian,
Black, White, etc. African 1 Never Married 2 X Married pernit. Page 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or <u>&</u> Maryland 21215-0036 1 ☐ Yes 2X☐ No Specify: Specify: American Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Park Heights Comm. Elementary/Seconday (0-12) College (1-4 or 5+) 12th Grade and Family Center <u>Transport</u> Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Julious Burton Estelle Burton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hanifah Winder-Daughter 4204 Main Avenue Baltimore, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Mem. Pk. injury or 08-18-10 Randallstown, MD 21. Signature of Funeral Service Licensee Wylie Funeral Home P.A. 22. Name and Address of Facility 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only on Immediate Cause (Final Onset and Death Physician, disease or condition resulting in death) Medical Due to (or as consequence of) Examiner seque, tight life or office, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 ate has been signed by the attending page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 🗖 No 3 ☐ Probably 4 ☐ Unknown Completed Cardiomyopaty 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page 1 Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 160 မ 1 Inpatient 2 Inpatient 3 Inpatient 2 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 10 Natural 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No. Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide 28f. Location (Street and Number or Rural Route Number determined Medical Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 40064267 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day,

87

COLTINT BICLES

32. Registrar Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

		•	1 - For State Registrar	Claid of W	arylana /		ificate of L	Death		Reg. No.	2010	25959
	Physicia Media	cal		drich					2. Date of De Month		2 o/o	3. Time of Death
set.	Examir	ier	4a. Facility Name (if not institution, of Baltimore Wash	ington Medi	cal Cent	ter	Gle	n Bur	nie		County of Death	Arunde/
ı	Funeral Director		578-26-6752		e (In yrs. last bi		If Under Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bird (Month, Da Nov. 9	th y, Year 192	9. Birth Was	nplace (State or Foreign ntry) hington D.C
	laryland 3a-f show iffied at	Director	Usual Residence of Decedent 10a. State 10b. County MD Anne A	runde1	10c. City, Tov		tion					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the M s 23a or 28 ust be not	Funeral Dir	10e. Street and Number 7648 Sandy Farm	Road			10f. Zip Code	21144		_	zen of What Cou	
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ঐ Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.		If \	is Decedent of Hi res, specify Cuba	ispanic Origin? (Spin, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		4. Race - Ameri Black, White, Specify: WI	
Baltimore, Maryland 21215-0036	vithin 72 hou liene. er than "nat the Medica	Completed	15. Decedent (Specify only highest Elementary/Seconday (0-12)		i+)	(Give kir	NOT use retired)	ation during most of wor cretary	king		nd of Business Ir	Contractor
/land	d be filed v Mental Hyg arked othe itic event,	To Be	17. Father's Name (First, Middle, Las John W. Bi	own					ne (First, Middle,		urname)	- Contractor
Mary	2 should th and N 7 is ma trauma		19a. Informant's Name/Relationship					and Number or Ru		r, City or To	own, State, Zip	Code)
nore, l	age 1 and sent of Healt of Healt of Healt of Y or other y or other		Mrs. Sarah Smith 20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spi		20b. Place	of Disposit	andy Far ion (Name of tory or other plac rematory	v : -	Date 18,		21144 cation - City or T n Burnie	
Baltir	permit. P Departme Importar any injur		21. Signature of Funeral Service Lice	ensee / /	101580	22. 1	Name and Addres	ss of Facility Si	010 l ngleton	Funer	ral & Cr	remation
)	Physician/ Medical Examiner	3r	23a. Part 1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. Aspira Due to (or as a				en Kurni	Approximate Interval Between Onset and Death			
8760	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Medical Examiner	if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence							
. Box 68	he death certifica y the attending p ched for use as '		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant & 9 Unknown	2 🔲 Fetal dea		Ectopic pregnanc Other (specify)	у		23	3d. Date of deliv Month	very Day Year
ords, P.O.		Completed by P	Part II. Other significant conditions Pneumo hrex Chronic borne	acute responsive Mulmon	ut not resulting	1, 1	erlying cause give	1	23e. Did to	F es 2□	No 3□ Pro	he cause of death? bbably 4 Unknown ppsy findings available
ž	sician: The law certificate has l irector, page 2 s		25. Was case referred to medical	To gotto	9 4.7				autop perfor 1 🗆 Yes		prior to co death? 1 \(\sum \) Yes	mpletion of cause of
Vita	ding Physician: h. After this certific funeral director,	To Be	examiner? 1 ☐ Yes 2 ➤ No		ent 2 ER/O		Otho	ace of Death (Checer: 4 Nursing H	ome 5 Resid	ence 6	Other (Specify	1)
Division of	Attending Physician: r death. ector: After this certific by the funeral director.	Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigat 3 Suicide 6 Could no	he	Year)	Time of injury			28d. Describe h			
	Io the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu		4 Homicide determine	building, etc	. (Specify)				City or Tow	n, State)	Number or Rura	
	the Hos hin 24 ho the Fun npleted	Medical	(Check 2 Medical Exa only one) 3 Certifying N	nysician: To the best of miner: On the basis of exurse Practioner: To the l	amination and/	or investiga	tion, in my opinion th occurred at the	n, death occurred a time, date and pla	it the time, date ar	nd place, a	and due to the ca	use(s) and manner stated.
	o 10 with		29b. Signature and little of certifier	Coller	MD.	?	29c. License	8240		Augi	signed (Month,	20/0
1			30. Name and address of person who Vadim Korkho	v 30/	Hospit.	(Type, Prin	Drive	, Gler	Bur	nie,	MD 2	1061
	Stat Registra	e	31. Date filed (Month, Day, Year) AUG 1920	32 Registra	r's Signature	par	New York			·		

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25960 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Emma Adams 08 2010 10:30A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Glen Burnie Health & Rehabilitation Glen Burnie Anne Arundel Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) 1 - M 2 XF Months Days Hours Min. Director 217-16-6040 /06/1925 Maryland Usual Residence of Decedent 28a-f shov ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County rector 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel Pasadena 1 Yes 2 X No ā 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8313 Fairwood Drive 21122 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 X Married within 72 hours after δ 2 X No Baltimore, Maryland 21215-0036 ☐ Yes If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural" 3 Widowed 4 Divorced Specify: White Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Home Maker Own Home Be . Page 1 and 2 should be filed ment of Health and Mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Linton Pumphrey Emma Reinecke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Mr. Douglas Adams / Son <u>6504 Grason Court</u> Bowie, MD 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Durial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2010 Glen Burnie, MD Crematory Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation M01220 Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or rest irratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of: ILMONAR Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and thed for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnar 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mont Pregnant at time of death 5 Other (specify) Month Day Year been signed by the should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaceo use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page performe 2 🗆 No 1 Yes 25. Was case referred to munical Be 26. Place of Death (Check only one) Hospital Other: မ 1 Tyes 2 N M6 1 Inpatient 2 ER/Outpatient 3 DOA Tursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature a le of certifie 29c. License num

Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Harjit Singh M.D.

31. Date filed (Month, Day, Year)

5410 A Ritchie Highway Brooklyn Park MD 21225

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 26,27 per np, good Deperment 26 Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. I. Decedent's Name (First Middle, Last) 2. Date of Death Month 3. Time of Death Physician/ 4:55 AM Medical give street and number 4c. County of Death Examiner If Under 24 Hrs 8. Date of Birth (Month, Day, Ye 7. Age (In yrs. last birthday) Year 9. Birthplace (State or Foreign **Funeral** Days 1 🗆 M 2 💢 F Months Min. Yrs. Director 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any Injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Baltimore 1 X Yes 2 □ No Street and Numb 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Rlaci 3 Divorced 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life, DO NOT use retired) Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Ante NUKSINU SSISTANT Be Father's Name (First, Middle, Last) 18. Mother's Name ပ္ Huskano 20a, Method of Disposition 20b. Place of Disposition (Name Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signat e of reral Service Livensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, proximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Pancreati Cancer disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical してん / Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 You Month Pregnant at time of death 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 □ Probably 4 □ Unknown 1 🗌 Yes Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform Hospital or Attending Physician: The Yes 2 the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 **V**No မ Hospice 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 M Other (Specify) 27. Manner of Dea h Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation Director 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined e Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: in the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as attended. (Check To the I within 2 or by one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

anna 31. Date filed (Month, Day, Year) have

Registrar's Signature

4105

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701

AUG 192010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25962 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 2010 ELAINE August 8:45 p M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 206 DENISON STREET BALTIMORE N/A Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth Month, Day, Yes 1 □ M 2 🛣 F Months Hours Min. Director MARYLAND 61 217-46-3223 NOV. 1948 Usual Residence of Decedent or 28a-f shov 10a, State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1X Yes 2 ☐ No MARYLAND N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23aFuneral 206 DENNISON STREET 21229 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🕅 No Black, White, etc. "natural", or 1 Never Married 2 Married Completed by 1 Yes ; 1 ☐ Yes 2 💆 No Specify: 3 Widowed 4 Divorced Specify: BLACK Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important, If item 27 is marked other than ' any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12yrs PUBIC AFFAIRS CORDINATOR EDUCATION 5yrs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ EFRID BROWN RUTH WASHINGTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Waters/Mother 206 Dennison St, Baltimore, Maryland 21229 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1XXBurial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Asbury T.N. Church 08-21-10 Severna Park, Maryland Signatur of Fureral Sarybe to 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) 2000 Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or impury that initiated events the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Ectopic pregnancy Month Dav Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 1 NO 2 14 1 Tyes 25. Was case referred to medical Vital Be 26. Place of Death (Check only one) examiner? 2 1 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this o completed filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury work? 5 Pending 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifler 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse, Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the 29b. Signature and title of certifier Physiciar 30. Name and address of perso who completed cause of death (Item 23a) (Type, Print) Nilose

A DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

AUG 19

2010

32. Registrar's Signature

		_	For State Registrar	State of Marylar		tificate of L			Reg. No		0	25963
	Physicia		1. Decedent's Name (First, Middle, La	Diane		Brooks		2. Date of De Month 08	eath	ay Ye	ear	3. Time of Death
	Medic Examin		Cecelia 4a. Facility Name (if not institution, giv				r Location of Deat		$\overline{}$. County of	010 Death	8:10a ^M
	=2011111		1427 North Ell	amont Street			imore					
	Funeral Director		5. Social Security Number 6. S	Sex 7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Da		53	l. Birthpla Countr	ace (State or Foreign MD
	and show d at	- 1	10a. State 10b. County	10c. Cit	y, Town or Loc	ation					10	d. Inside City Limits
	Maryl 28a-f otifie	irec	MD NA		Balti				-			1 X Yes 2 □ No
	s 23a or	Funeral Director	10e. Street and Number 1427 North Ell	amont Street		10f. Zip Code 21	216		10g. C	itizen of Wha		ry?
Baltimore, Maryland 21215-0036	permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Be Completed by Fur	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Year or Dates.		Vas Decedent of H Yes, specify Cuba		pecify Yes or No- o Rican, etc.)		14. Race - Black, \ Specify:	White, et	
15-(72 hou n "nat ledica	nple	15. Decedent's (Specify only highest g	rade completed)	(Give k	ent's Usual Occup ind of work done of NOT use retired)	ation during most of wo	rking	16b. F	Kind of Busin	ness Indu	ustry
212	within giene. er tha	ខ្ញុ	Elementary/Seconday (0-12) 12th grade	College (1-4 or 5+) na	1	ts Coor	dinato	:s	Ca	rita	Нοι	use
pu	e filed tal Hyged oth event	To Be	17. Father's Name (First, Middle, Last)					me (First, Middle	, Maiden	Surname)	-	
<u> </u>	d Men marke	-	Willis Lancast		1		Helen H					
Ma	12 shouth and the and		19a. Informant's Name/Relationship (Timothy S. Bro			g Address (Street a						ode) 21216
ore,	of Hear of Hear fitem		20a. Method of Disposition	20b. F	Place of Dispos	sition (Name of patory or other place		Date Date		ocation - Cit		
ij	, Page Iment tant: I jury o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	ify) Ch	elten	ham Vet	8/2	3/2010	Ch	elte	nhar	m, Md
Ball	permit Depart Import any inj		21. Signature of Funeral Service Licer	Hahar	22. Ma Ma	Name and Addrese F/H	ss of Facility West	. Balti	mor	e. Mo	d 2.	1215
			23a. Part 1. Enter the disease, or con shock, or heart failure. List only	nplications that caused the deat								Approximate Interval Between
_	nysician/ Medical	St 3	Immediate Cause (Final disease or condition resulting in death)			HEA	RT FAI	LURE			F	Onset and Death BwwbEbKS
-	Examiner		rooding in doding	Due to (or as a consequ	uence of):							
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequence)	uence of):							
	scuted and transit	Examiner	Cause (Disease or linjury that initiated events	c. Due to (or as a consequ	uongo ofi:							
0			resulting in death) Last	d.	derice ott.							
8760	, E 50	Med	IF FEMALE:									
Division of Vital Records, P.O. Box 68	Hospital or Attending Physician: The law requires that the death certific 44 hours after det.h. Funeral Director. After this certificate has been signed by the attending sted filled in by the funeral director, page 2 should be detached for use as		23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1 Live Birth 2 Fet 4 Pregnant at time of of	al death 3 🗆	Ectopic pregnand Other (specify)	Э У			23d. Date of Month		ry Day Year
ls, P.O	uires that the signed by the detail	ed by Pl	Part II. Other significant conditions	contributing to death but not res	ulting in the u	nderlying cause giv	ven in Part I.					e cause of death?
Sorc	iw requals been 2 shou	Completed						24a. Was auto		24b. Wer	e autops	sy findings available apletion of cause of
Rec	Physician: The law this certificate has al director, page 2 9	ခြီ မြ						perfo	ormed?	dea	th? Yes 2	
ital	sician; certific rector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		Oth	ace of Death (Che	-				
of V	y Physer this eral dii	은 등	27. Manner of Death	1 Inpatient 2 28a. Date of injury	28b. Time of	28c. Injun	4	dome 5 Resi			Specify)	
5	ending seth. or Afte he fun	ficat	1 Natural 5 Pending 2 Accident Investigation		injury	M 1 🗆	Yes 2 No					
Ofvisi	al or Att s after d I Direct	Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined		ome, farm, stre	et, factory, office		28f. Location (City or Tov			r Rural F	Route Number,
F	To the Hospital or Attending Phywithin 24 hours after decth. To the Funeral Director After th completed filled in by the funeral	Medical	(Check 2 Medical Exam	vsician: To the best of my know niner: On the basis of examinatio rse Practioner: To the best of m	n and/or investi	gation, in my opinio	on, death occurred	at the time, date a	and place	e, and due to	the caus	se(s) and manner stated.
	To the within 7 To the comple		29b. Signature and title of certifie	-) - MO		29c. License			29d. Da	ate signed (N	1onth, Da	ay, Year)
$\vec{\lambda}$	'		30. Name and address of person who	completed cause of death (Item	23a) (Type, P					40 21		7
V (State	-	31. Date filed (Month, Day, Year)	32. Registrar's signa	parko		14.5.7	//	-7	7 -	` '	
	Registra	r	AUG 1 9 2010	Land In .								

DHMH 17 Rev 7/2009

10-06042									
Charles Booth									

Physician/ Medical Examiner

Funeral Director

Please Type or Brint in Plack Indelik	bla l	nk Engum	a All Cani				
Please Type or Print in Black Indelit amend #10 State of Mary 1916 / Bebart Ne	in I	THE SHEET	e All Copi	es Are Le	gible.		
			a Mentai F	rygiene	- 2	010	25964
Registrar	ite oi	f Death		Re	g. No.	9.0	
Decedent's Name (First, Middle,Last)				2. Date of Dear		ν.	3. Time of Death
Charles Booth				Month August 12	, 2010	Year	0150 hrs
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Dea	th	4c. C	ounty of Deat	h
Gilchrist Hospital	ı	Baltimore			Baltimore County		
5. Social Security Number 6. Sex 7. Age (In yrs. last birthe	day)	If Under 1 Yea	r If Under 24Hi	rs. 8. Date of Bir	th (MM/DD	YYYY) 9. Bi	rthplace (State or
212-34-3712 1×M 20F 81	Yrs	Months Day	s Hours Mi	— 1- · · · · · · · · · · · · · · · · · ·			
Usual Residence of Decedent							
10a. State 10b. County 10c. City, Town or	r Locati	tion Bal	timore				10d. Inside City Limits
Maryland NIA 2402	T.	conestion	0.	e Ant	14		1 🔀 Yes 2 🗌 No
10e. Street and Number		10f. Zip Code 10g. Citizen of What Country?					intry?
2402 Tronesha Road Apt. 10	4	2122	-7	(la te	& Stat	45
	13. Wa	as Decedent of His	panic Origin? (S	pecify Yes or No-			ican Indian, Black,
1 Never Married 2 Married Armed Forces?	If Y	Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc.					
Widowed 4 Divorced If Yes, Give Year or Dates:	1	Yes 2 ✓ No	specify:		Spe	ecity: Wh	ite
		nt's Usual Occupat			16b. Kind	of 8usiness/	Industry
Elementary/Secondary (0-12) College (1-4 or 5+)		ost of working life.	DO NOT use re	tirea)			
//	Sal	eman			Si	ales	
17. Father's Name (First, Middle, Last)			18.Mother's Nam	e (First, Middle, M	laiden Sur	name)	
UNKHOWN			UNKN	2WN			ĺ
19a. Informant's Name/Relationship (Type, Print). 19b.	Mailing	g Address (Stree	and Number or	Rural Route Num	ber, City o	r Town, State	e, Zip Code)
Danton Fisher - Administrator 10		110	11/1	01	2 11	~	11021110

Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Fleath and Mental Hygene. Important: If iten 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. Physician /Medical

Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Division of Vital Records, P.O. Box 68760,

5	Maryland NIA	2102	7 100	ESHA K	sal And	LIA	1 Yes 2 No				
ect	10e. Street and Number		10f.	Zip Code		10g. Citizen of What Cou	intry?				
Funeral Director	2402 Tronesha Road	1 Apt. 1	A :	21227		Clarked States					
Jer.	11. Marital Status 1 Never Married 2 Married Armed Forces?	Ever in U.S.	13. Was Dece If Yes, spe	edent of Hispanic Orig ecify Cuban, Mexican,	in? (Specify Yes or N	No- 14. Race - Amer White, etc.	rican Indian, Black,				
[큔	1 Yes 2	* No			7 22.10 11.021., 010.)		1				
≦	3 Widowed 4 Divorced If Yes, Give Year or Dates:			2 No specify:		Specify: Wh	ite				
eg	15. Decedent's Education (Specify only highest grade com			al Occupation (Give k vorking life, DO NOT		16b. Kind of 8usiness/	Industry				
Completed by	Elementary/Secondary (0-12) College (1-4 or 5)+)	,	_	•	C. C.					
Eo	17. Father's Name (First, Middle, Last)		Salen			Sales					
Be C					s Name (First, Middle	, Maiden Surname)					
ToB	Unk HINA 19a. Informant's Name/Relationship (Type, Print)	10	Mailing Addre		KNIWN	umber, City or Town, State	7. 0 1.				
-	19a. Informant's Name/Relationship (Type, Print.) D6 n + on i Fisher - Admir Istro 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from Sta	Far	o. Maning Addre	ss (Street and Numi	oer or Rural Route Ni	Imber, City or Town, State	e, Zip Code)				
	20a. Method of Disposition	20h Place c	of Disposition (A	A K.OCK G	len Kd	Daltinove,	MD 2/229				
	1 Burial 2 Cremation 3 Removal from Sta	te cremate	ory or other pla	ce)	A a	200. Location - City of	Town, State				
	4 Denation 5 Other Specify:	Mount	Carmel	Cem.	Hus 20, 2011	O Baltimore	, MD				
	21. on- ure of Funeral Service Lice se		22. Name a	nd Address of Facility	. 1 Hms Fr	S. P.H.					
			270	Fredhil	ton Poss	S. P.H. Beltomore	· no				
	23a. Part I. Enter the disease, or complications that caused t failure. List only one cause on each line.	he death. Do no	t enter the mod	e of dying, such as ca	rdiac or respiratory a	rrest, shock, or heart	Approximate Interval Between Onset and				
	Immediate Cause (Final disease a. Complications of fall										
	or condition resulting in death) Due to (or as a consequence of):										
-	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):										
Ë	cause. Chier Underlying Cause (Disease of injury that initiated C.										
Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										
	d										
Physician/Medical	X UNPENDED AMENDED PII.	27,28a-	f, per	ME g908 10)/4/10 TT						
/We	23h Was decedent pregnant in the	e of pregnancy		8, 4, 5,	7 .7 20 22	23d. Date of delivery	,				
ian	part 12 months?	2 ime of death 5			pregnancy	Month E	ay Year				
Sic	1 Yes 2 No 9 Unknown 9 Unknown	me or death 5	Other (Sp	ecify)							
F.	Part II. Other significant conditions contributing to death	but not resulting	in the underlyi	no cause given in Part	11 23e Did 1	tobacco use contribute to	the cause of death?				
Completed by	1/	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Dementia; Hypertensive atheroslcoeritc cardiovasculac 1 Yes 2 No 3 Probably 4 Unknown									
ted	24e Was an 24e Was and 5 edition of the										
흵	<u>disease; Metastatic pros</u>	tatic c	arcinom	a;	auto	psy prior to c	ompletion of cause of				
칫	Chronic obstructive pulmonary disease performed? death? 1 ✓ Yes 2 ☐ No										
Be	25. Was case referred to medical examiner?	25. Was case referred to medical 26.Place of Death (Check only one)									
P	examiner? 1 Yes 2 No Hospital: 1 Inpatien	t 2 ER/Out	tpatient 3	DOA Other	Nursing Home 5	Residence 6 Other	:				
	27. Manner of Death 28a. Date of Injury (Month, Day,Yes	ar)				how injury occurred					
ji	Natural 5 Pending June, 20	I I V. al III leithiach				: fell					
읣		ry - At home, far		y, office building, etc.		Street and Number or Rui					
9	4 Homicide determined (Specify)	Nursin	g Home		Baltim	ore, MD. Roc	ck Gren Roa				
Medical Certification:	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
ğ	one) 2 Medical Examiner: On the basis of exami	nation and/or inv	vestigation, in n	ny opinion, death occu	urred at the time, date	and place, and due to the	e cause(s)				
žΓ	29b. Signature and title of certifier		29	c. License number		29d. Date signed (Mon	th Day Year)				

O.C.M.E.

UCIVIE

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

August 12, 2010

State

Registrar

Assistant Medical Examiner

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

Ana Rubio MD.

31. Date filed (Month, Day, Year)

			For	State	of Marylan		rtment				_ / U	10	25965
			Registrar 1. Decedent's Name (First, Middle	Last)			incate	Or DCar		2. Date of Dea	Reg. No.		3. Time of Death
	Physicia	n/	Frances		OC47	To				Hiela	Day 9	7010	1052 M
	Medic	_	4a. Facility Name (if not institution,				4b. City, To	wn, or Loca	tion of Death	11 3	4c. Coun	ty of Death	
	Examin	er	6 D Street NW				Gler	Burn	nie		Anne	Arund	le1
A.A.	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)			Inder 24 Hrs.	8. Date of Birt	h Voor)		place (State or Foreign
	Director		218-18-1602	1 □ M 2 🕅 F	86	Yrs.	Months [Days Ho	urs Min.	10-22-	1923	Cour	Virginia
ż	3		Usual Residence of Decedent		1.0 0								10d. Inside City Limits
200	f sho	tor	10a. State 10b. County	Arunda1	10c. Cit	y, Town or Loc	Burni	٥				1	1 ☐ Yes 2 🎇 No
1	Mary 28a- otifie	Director										1 1 M/h = 4 C = 11	
4	a or be n							10f. Zip Code				10g. Citizen of What Country? USA	
	ns 23	Funeral	6 D Street NW	Tao W. B	- Joseph Commission (1)	0 110 1		21061	ic Origin? (Spe	cify Yes or No-	14 0	ace - Ameri	
-	r iter		11. Marital Status1 ☐ Never Married 2 ☐ Married	12. Was Dec	edent Ever in U.: orces? 2 X No	5. 13. V	Yes, specify	Cuban, Me	exican, Puerto	Rican, etc.)		ack, White,	
2	all", o	d by	3 XWidowed 4 ☐ Divorced	If Vac Gi	ve	1	☐ Yes 2	XINo Sp	ecify:		Speci	fy: whi	te
5	atura cel E	Completed	15. Deceder	nt's Education		16a. Deced	ent's Usual (Occupation	4 - 6		16b. Kind of	Business Ir	ndustry
2	an "n Medi	ם	(Specify only higher Elementary/Seconday (0-12)	est grade completed College (aind of work of NOT use re		most of worki	ng	Lega1	Firm	L
7	withir giene er th the		Elementally/occorday (o 12)	2		2	Secret	ary					
2 ;	al Hy d oth	Be C	17. Father's Name (First, Middle, I							e (First, Middle,		me)	
9	d be Menta arked atic e	잍	John C. W	oodell						Thitake:			
0	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If Health and Mental Hygiene. If marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medic⊸l Examiner must be notified at		19a. Informant's Name/Relations			19b. Mailir	ng Address (S 5 Day	Street and N Farm	lumber or Rura Rd. G	l Route Numbe	r, City or Town MD 2.1	, State, Zip . 737	Code)
≥ : '`	and 2 lealth im 27 her tu		Paul Hughes / s	on	on.	Place of Dispo				Date	20c. Locatio		Town State
5	Page 1 a ment of H ant; If ite ury or ot		20a. Method of Disposition 1 XBurial 2 ☐ Cremation	3 Removal from	n State	cemetery, cren	natory or oth	er place)	i	/2010	Glen 1	-	
	t. Pag tmen rtant: rjury		4 Donation 5 Other (GTO	en Have							
	permit, Page 1 Department of Important; If i any injury or o		21. Six atur Funera Service	censee	MO1	364 4	21 Cra	in Hw	rv SE G	rkley-Ru Len Buri	uddick nie MD	Funer 21061	al Home
			23a. Part 1. Enter the disease	r complications that									Approximate
1			shock, or heart failure. List of Immediate Cause (Final	only one cause on e	ach ine.					2000		t	Interval Between Onset and Death
P	nysician/ Medical		disease or condition resulting in death)	a. Dua to	o (or as a consec		wh'	<u>C</u>	Caro	DUNG	cuco	7 1	oca p
25.00	Examiner			Due io	(0) 43 4 0011000	140/100 0.).							
		ē	Sequentially list conditions,	b. Due to	(or as a conse	uence of :							
1	ted Insit	Examiner	cause. Enter Underlying Cause (Disease or iinjury										
	execu in and ial-tra	Ä	that initiated events resulting in death) Last	Due to	(or as a consec	uence of):							
2	ding Physician: The law requires that the death certificate be executed in. After this certificate has been signed by the attending physician and fameral director, page 2 should be detached for use as the burial-transit	dical		d									
00/00	incate ing phi as th	Neg	IF FEMALE:										
ĕ	endir endir	an/l	23b. Was decedent pregnant	23c. If yes, or	utcome of pregn e Birth 2 Fe	tal death 3 L	Ectopic pr					Date of deli Month	very Day Year
POX	death	sici	in the past 12 months? 1 Yes 2 No	4 ☐ Pre 9 ☐ Un	gnant at time of known	death 5 L	Other (spe	cify)				VIOLITI	Day 100
- -	t the by th	Physician/Med	g Unknown Part II. Other significant conditi	inne contributing to	dooth but not re	eulting in the I	ınderlyina ca	use given ir	n Part I.	23e Did	tohacco use co	ontribute to	the cause of death?
л Э	s tha gned be de	þ	Part II. Other significant conditi	ons contributing to	death but not re	Saiting in the C	and only in 19 ou	g.ve.v.					obably 4 Unknown
Records,	equire sen si ould	ted											opsy findings available
် ပ	aw re as be	Completed								24a. Was	psy	prior to death?	completion of cause of
r T	The I	5									ormed? 2 No		2 🗆 No
VITal	cian: ertific ector,	Be	25. Was case referred to medical examiner?	Hospital:				Other:	of Death (Chec				
>	Physi this c	은	1 Yes 2 No 27. Manner of Death	1 1	Inpatient 2	ER/Outpatie		A 4	I ☐ Nursing He	ome 5 Res	idence 6 L C		ify)
0	ling F I. After funera	ate	1 Natural 5 Pendi	ing (Mo	onth, Day, Year)	injury	M 20	work?	2 □ No	200. Describe	now injury coo	u ii o u	
<u> </u>	ttenc death stor: /	Certificate:	3 Suicide 6 Could		ce of Injury - At h	nome, farm, st				28f. Location	Street and Nui	nber or Rui	ral Route Number,
Division of	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Ş	4 Homicide determ	mined buil	ding, etc. (Speci	fy)				City or To	wn, State)		
2	spita spita neral fillec	<u>sa</u>	29a. Certifier Certifyîn	g Physician: To the	best of my know	wledge, death	occured at t	he time, dat	te and place, a	nd due to the c	ause(s) and ma	nner as sta	ited. cause(s) and manner stated.
	ne Ho n 24 l ne Fu	Medical	(Check 2 Medical only one) 3 Certifyin	Examiner: On the b g Nurse Practione	asis of examinati r. To the best of r	on and/or inves ny knowledge,	death occurr	ed at the tim	ne, date and pla	ce, and due to t	he cause(s) and	manner as	stated.
	Vith Vor		29b. Signature and title of certific	er /	2		29c.	License nur	mber	,	29d Date sig	,	0 -
			190	1000	1/)15	8/0	<u> </u>	Hug	de of	7,2010
		1	30. Name and address of person		use of death (Ite	m 23a) (Type,	Print)	Lin	al.	150	61	V.	>1061
			31. Date filed (Month, Day, Year)	19019(1)	Registrar's Sign	nature 4	BORA A	100	701	, July	·		
	Sta Registr		AliG	192010	Leneus	U p.	1900						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 0 25966 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2 Month Physician/ Harriet Elizabeth Brown 23/56PM 11 2010 Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Imons Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Country) MD Months Hours Min. 9 - (Mosth, Pay 179" 212-10-4355 90 Director Usual Residence of Decedent shov ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Baltimore Catonsville 1 ☐ Yes 2 🗓 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 715 Maiden Choice Ln, Harborview #317 21228 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?...
1 Yes 2 ANo Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: If Yes, Give Year or Dates Specify: white 3 X Widowed 4 Divorced 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Home Maker Home Owner Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked out any injury or other traumatic evenvoice. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William E. Herbert Edna Harvey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol E Wick/daughter 1834 Ridgewick Rd Glen Burnie MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 8-16-10 Elkridge, MD Donation 5 Other (Specify) Meadowridge Mem Prk of un al Ser 22. Name and Address of Facility 22. Name and Address of Facility Kirkley-Ruddick Funeral Home 421 Crain Hwy SE Glen Burnie MD 21061 M01364 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between
Onset and Death
HOUR Immediate Cause (Final Physician RUPTURED THORACIC AURTIC disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or se a consequence of): attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be extanced and the death.

Funeral Director: After this certificate has been signed by the attending physicial. P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day 1 ☐ Yes 2 ₩ 9 ☐ Unknown Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vítal Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pendina work? Accident Investigation 2 🗌 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier D0051865 usto ST AGRES HUSPITAL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 17Ancos

State Registrar

30

32. Regist ar's Signature

			State of Maryland				nd Mental Hy	/giene	10 05065		
			Registrar 1. Decedent's Name (First, Middle, Last)	Cer	tificate of D	<i>Jeatn</i>	2. Date of D	Reg. No.	10 2596		
	Physicia		Thomas Brabham		te of Death Onth 8/17/2010 Year 5:15 A M						
, alimana,	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of [4c. County of D			
7			Brinton Woods Health Care Cen	iter	Sykes	sville		Carı	roll		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last		If Under 1 Year Months Days	If Under 24 Hours			Birthplace (State or Foreign Country)		
	Director		216-28-2661 1 80 Usual Residence of Decedent	Yrs.			Min. 6/28/	1930	MD		
	and show	ō		Town or Loc	cation				10d. Inside City Limits		
	Maryl 28a-f otifie	rec	MD Carroll	Wood	bine				1 🗆 Yes 2🏝 No		
	h the ha or he n	al D	10e. Street and Number		10f. Zip Code			10g. Citizen of What	Country?		
	th wit	Funeral Director	1810 Gillis Rd.		2179			USA			
10	r dea	by Fu	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 12. Wes Decedent Ever in U.S. Armed Forces? 12. Yes 2 \(\subseteq \) No	13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin n, Mexican, P	? (Specify Yes or No uerto Rican, etc.)	14. Race - A Black, W	merican Indian, /hite, etc.		
030	s afte ral", o		3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates. 1955-6.	3 1	☐ Yes 2 🗷 No	Specify:		Specify:	White		
2-0	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed		16a. Deced	lent's Usual Occupa		working	16b. Kind of Busine	ess Industry		
2	hin 72 ne. than '	om	Elementary/Seconday (0-12) College (1-4 or 5+)	life. DO	O NOT use retired)	uring most of	working				
П	Hygie Hygie other ent, th	Be C	12 17. Father's Name (First, Middle, Last)	Dair	y Farmer	10 Mathanta	No. of Contract of the Contrac	Self-Emp	Loyed		
au	2 should be filed within 72 th and Mental Hygiene. It is marked other than " traumatic event, the Mec	To I	William Vernon Brabham				Name (First, Middle che Viole				
ary	nd Mind Mind Mind Mind Mind Mind Mind Mi		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	a Address (Street a			er, City or Town, State,	Zip Code)		
Σ	id 2 sh ealth a n 27 is		John Brabham/Brother				loodbine,	-	_,,		
ore	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Heath and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 20b. Place	ce of Dispos	sition (Name of natory or other place	9)	Date	20c. Location - City	or Town, State		
Ē	Page 1 tment of 1 tant: If it jury or o	3	4 Denation 5 Other (Specify)	arrol.	l Cremato	ry 8/		Winfield			
Baltimore, Maryland 21215-0036	permit. Page 1 Department of Important: If i any injury or once.		21. Signature o Funeral Service Licensee	22	Name and Addres Burrier-Q	s of Facility ueen F	uneral Ho	me & Crema	tory, P.A.		
		-	23a. Fart 1. Enter the disease, or complications that caused the death.		<u> 1212 W. O</u>	ld Lib	erty Rd.	Winfield.	MD 21784		
	Ph. sician/		shock, of heart failure. List only one cause on each ling. Immediate Cause (Final	. 13	idocadi	-	diac of respiratory a	ireat,	Approximate Interval Between Osset and Death		
	Medical		disk se of condition resulting in death) a. Due to (or as a consequer		iacaa	w			12000		
	Examiner	L	So controlly list over the second								
	sit d	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):								
	ecute and I-trans	Exar	Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of):								
0	be ex sician buria	dical		,							
3760	ficate g phy as the	Jedi	_ u								
x 687	endin r use	an/	IF FEMALE: 23b. Was decedent pregnant in the post 13 months? 23c. If yes, outcome of pregnanc		Ectopic pregnancy	,		23d. Date of	delivery		
Box	the att	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 1 ☐ Ve Brit 2 ☐ Fetal of 4 ☐ Pregnant at time of dea 9 ☐ Unknown		Other (specify)	<u>'</u>		Month	Day Year		
o.	at the od by 1 detack	Ph.	Part II. Other significant conditions contributing to death but not resulti	ing in the ur	nderlying cause give	en in Part I.	23e. Did t	obacco use contribute	e to the cause of death?		
s, D.	ires th signe d be d	d b	HORTIC STENDSIS						Probably 4 Unknown		
ord	requipers	Completed					24a. Was		autopsy findings available		
ec	he lav te has age 2	mo					— auto	ormed? death			
<u>a</u>	an: T		25. Was case referred to medical examiner?		26. Pla	ce of Death (1 □ Yes Check only one)	2. No 1	Yes 2 No		
<u> </u>	hysic lis ce	2	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ EF	R/Outpatient	3 DOA Other	r: 4 🗷 Nursir	ng Home 5 🗆 Resi	dence 6 Other (Sp	pecify)		
o	ing Pl		27. Manner Death 28a. Date of injury (Month, Day, Year) 28 Date of injury (Month, Day, Year)	3b. Time of injury	28c. Injury work?		1	how injury occurred			
300	ttend death stor: / / the f	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	o form otro		res 2 □ No		0	5 15 11		
Division of Vital Records,			4 Homicide determined building, etc. (Specify)	e, iann, stre	et, factory, office	office 28f. Location (Street and Number or Rural Route Number, City or Town, State)					
_	ospita hours uneral	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowled	ge, death o	ccured at the time,	date and place	ce, and due to the ca	use(s) and manner as	stated.		
	the H	Med	(Check 2 Medical Examiner: On the basis of examination are only one) Certifying Nurse Practice: To the best of my kn	nd/or investi nowledge, d	gation, in my opinior eath occurred at the	n, death occur time, date and	red at the time, date a d place, and due to the	and place, and due to the cause(s) and manner	ne cause(s) and manner stated. as stated.		
	2 with 2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		29b. Signature and title of certifier		29c. License	-		29d. Date signed (M)	Inth, Day, Year)		
			fallet L	- Ohar-		806	72	8/14/0	(010		
1			30. Name and address of person who completed cause of death (Item 23		int)	retor 1	V Por	testan &	D 21136		
	Stat	е	31. Date filed (Month, Day, Year) 32. Registrar's Signature		1	- 11c - 12	NO	70/0-1			
	Registra	r	AUG 192010 January 19. 19	general							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ZOI Öar RAMOR Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 110 pkins ohh 59/timore 591 Social Security Number If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2🛣 F Months Hours Min (Month, Day, Year) Director 215-32-10-193 MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore 1 X Yes 2 No Edgemere 10f. Zip Code 10g. Citizen of What Country? Funeral 2825 Lodge Farm Rd., Apt. 21219 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No If Yes, Give Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 6 Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Steven R. Lotz - Son</u> Bridgewood Dr., Baltimore, MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory | 8-16-20<u>10 Baltimore, MD</u> 22. Name and Address of Facility Bradley-Ashton Funeral Home 21. Signature of Funeral Service Licersee 2134 Willow Spring Road, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death ps: Physician Se disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Ganr rehe Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or impury Examine the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-trans attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 5 Other (specify) Month Year cate has been signed by the a page 2 should be detached 1 | Yes 2 | 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 D Unknown Director: After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: ၉ 1 🔲 Yes 2 No 1 Ninpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No hours after death Investigation Accident 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide within 24 hours area. ____
To the Funeral Director 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🖂 only one) 29b. Signature and title

State Registrar 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10-06134 Donald Carter Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Certifi	icate of Death		Reg	Z U 1	0 2596
Physici Medical Exam		1. Decedent's Name (First, Middle,Last)	Carter			2. Date of Death Month August 16,	1	3. Time of Death 1447 hrs
		4a. Facility Name (if not institution, give University Hospital		Baltimore	or Location of Deatl	h	4c. County of Death	1A
Funeral Director		5. Social Security Number 6. Sex 213-90-3155 1 Value Usual Residence of Decedent	7. Age (In yrs. last b	oirthday) If Under 1 Ye Months Da			Foreig	thplace (State or gn untry) MD
and show any nce.	5	10a. State 10b. County	10c. City, Tow	0 11.	ore			10d. Inside City Limits 1 Yes 2 No
with the Maryland ms 23a or 28a-f show be notified at once.	I Director	10e. Street and Number 860 Kels	30 Dr Apt	304 21	1221	10g	g. Citizen of What Cour	ntry?
er death with	Funeral	1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year	13. Was Decedent of Hi If Yes, specify Cuba	an, Mexican, Puerto	pecify Yes or No- Rican, etc.)	White, etc.	can Indian, Black,
5-0036 led within 72 hours after dygiene. other than "natural", the Medical Examiner	eted by	45 Deceded 5 Education (C. 15	or Dates:	Yes 2 V No Decedent's Usual Occupa during most of working life	ation (Give kind of		Specify: D	ndustry
	e Completed	17. Father's Name (First, Middle, Last)	vlar.	Entrepr	18.Mother's Name	e (First, Middle, Ma	Self	Employed
imore, MD 21215. Pages I and 2 should be filed ment of Health and Mental Hy tant: If item 27 is marked of or other traumatic event, the	To Be	19a. Informant's Name/Relationship (Type Mamie Farrot		9b. Mailing Address (Stre	eet and Number or P	Rural Route Number Apr 361	er, City or Town, State, 4 Palto	Zip Code) MD 21771
ore, Nest and of Health If item		20a. Method of Disposition	20b. Place	e of Disposition (Name of ce atory or other place)	emetery, P/8		20c. Location - City or	Town, State
Balt permit. Depart Impor injury		21. Sulture.of Funeral ce Licins	well St.	22. Name and Addres	berty H	eign+s	Fuxura Ave Pal	1 HO 2170
Physician /Medical Examiner		The state of the s	cations that caused the death. Do r h line. Multiple Gunshot Wounds v ue to (or as a consequence of):		, such as cardiac o	r respiratory arrest	i, shock, or heart	Approximate Interval Between Onset and Death
	ner	Sequentially list conditions, b	ue to (or as a consequence of):					
ecuted and transit	l Examiner	(Disease or injury that initiated C	ue to (or as a consequence of):					
760, icate be executed physician and the burial - transi	Medical		AMENDED 23c. If yes, outcome of pregnancy				Load Date of delivery	
	sician/	23b. Was decedent pregnant in the past 12 months?	1 Live birth		Ectopic pregna	incy	23d. Date of delivery Month Di	ay Year
, P.O. Be ires that the de signed by the	2	Part II. Other significant conditions co		ng in the underlying cause o	given in Part I.		acco use contribute to the 2 No 3 Proba	
cords law requi	Completed					24a. Was an autopsy performe 1 Yes 2	prior to co	opsy findings available ompletion of cause of s 2 No
	Be	25. Was case referred to medical examiner?	soital:		of Death (Check of Other			harmonia .
on of Vinding Physical A. After this refuneral di	ion: To	1 ✓ Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year) 28b.	Time of Injury 28c. Injury	ury at Work?	g Home 5 Re 28d. Describe how Subject shot	v injury occurred	
Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifitely filled in by the funeral director,	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28a Place of Injury At home for	V. T-12.3-12.3-12.3-12.3-12.3-12.3-12.3-12.3	building, etc.	or Town, State	eet and Number or Rura e) lin Street, Baltimore,	
DIVI To the Hospital or within 24 hours afte To the Funeral Dir	edical	29a. Certifier (Check only one) 2 Medical Examiner: O	a: To the best of my knowledge, de on the basis of examination and/or in and manner stated.					
	Ž	29b. Signature and title of certifier	P	29c. Licens			9d. Date signed <i>(Mont</i> August 17, 2010	h, Day, Year)
)			mpleted cause of death (Item 23a) nt Medical Examiner 11	1 Penn Street, Baltin	more, MD 2120	01		
St. Regist		31. Date filed (Month, Day, Year) AUG 1 9 2010	32 Registrar's Signature	parke				

			1 - For Ame State Registrar	end Item	s State o	i Maryla Verb	nd / Dep Ce	087 F9/26 in the state of the	Ga llib and Death	d Mental Hy	giene (010	25970
	Physici	an	Decedent's Name Clarence	(First, Middle, La Martin	•					2. Date of De	Day	Year	3. Time of Death
7 8 1/2	/Medic Examin		4a. Facility Name (If	not institution, giv	e street and nu	mber)		4b. City, Town, o		ALICT eath		nty of Death	6.001
mar et a			Augsburg 5. Social Security Nu	Lutheran		7 Ago /In us	s. last birthday)	Baltimore If Under 1 Year	County If Under 24 H	rs 9 Date of Bi		imore	lace (State or Foreign
H	Funeral Director		217 36 3758		M 2□F	97	Yrs.	Months Days	Hours Mi	February	rth ay 22°41 913	Baltin	iore, Maryland
	and w.		Usual Residence of I	Decedent 10b. County		10c. (City, Town or Lo	cation				1	0d. Inside City Limits
	a-f sho	ctor	Maryland	Baltimore		Tin	monium						1 □Yes 2√√□No
	with the	Director	10e. Street and Num					10f. Zip Code 21093			10g. Citizen	of What Coun	try?
	ms 23	Funeral	3 Bird Hill 11. Marital Status	COUPT		edent Ever in		 Was Decedent of ⊢	lispanic Origin?	(Specify Yes or N	0- 14. F	Race - Americ	
980	72 hours after death with the Maryland natural", or items 23a or 28a-f show Jical Exemilian out be motified at	by	1 ☐ Never Marrie 3√3 Widowed 4		Armed For 1 ∐Yes If Yes, Gi Year or D	2 🔀 No ve	į	If Yes, specify Cuba 1 □ Yes 2 🗷 No	an, Mexican, Pu	erto Hican, etc.)		Black, White, e ecify: Whit	
15-0	n 72 hc "natu	Completed	(Special	15. Decedent's E fy only highest gra	ducation ade completed)		ı (Give	dent's Usual Occup kind of work done DO NOT use retired	durina most of v	vorking	16b. Kind of	f Business/Inc	dustry
212	d within giene. er than "I	Мо	Elementary/Secon	dary (0-12)	College (* N/A	1-4or 5+)	Farmer	DO NOT USE TOUTER			Self E	mployed	
land	should be filed vand Mental Hygies marked other iumatic event, the	To Be (17. Father's Name (F)					lame <i>(First, Middle</i> D Wholer	e, Maiden Surr	name)	
, Mar)	tra tra		19a. Informant's National David Dou		(Type. Print)		19b. Mailii PO Bo	ng Address (Street X 5516 Tows	and Number or on, Maryl	Rural Route Numb and 21285-	ber, City or Tol 5516	wn, State, Zip	Code)
Baltimore, Maryland 21215-0036	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other			osition Cremation 3 Other (Special		01-1-	cemetery, crei	esition (Name of matory or other place metery Augu		Date LO		on-City or To re, Mary	
Balt	permit. Depart Import any inj		21. agratus of Fur	eral Service Lice	nsee SSSM	0		2. Name and Addre SSahn Funer 01. Belair F			21236		
	Physician /Medical Examiner	ıer	23a. Part 1. Enter th shock, or hear Immediate Cause (f disease or condition resulting in death) Sequentially list condition, leading to immediate. Enter Under	t failure. List only final dittions.	Due to	caused the decach line. (or as a consector as a consector as a consector as a consector as a consector as a consector as a consector as a consector as a consector as a consector as a consector as a consector as a consec	JEROT equence of):	er the mode of dyir		140	1	Disc as	Approximate Interval Between Onset and Death
68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edical Examiner	cause. Enter Under Cause (Disease or it that initiated events resulting in death) La	njury	c	(or as a conse	equence of):						
P.O. Box	w requires that the death certific been signed by the attending p should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent in the past 12 n 1 □ Yes 2 □ 9 □ Unknown	nonths?		birth 2□Fe nant at time o	tal death 3	☐ Ectopic pregnand ☐ Other (specify)	у		23d.	Date of delive Month	ery Day Year
rds, P	quires that en signed b uld be deta	by	Part II. Other signific	cant conditions	contributing to d	eath but not re	esulting in the u	nderlying cause giv	en in Part I.		tobacco use c		ne cause of death?
Division of Vital Records,	iician: The law re certificate has bev ector, page 2 sho	Completed			1							prior to co death?	psy findings available mpletion of cause of 2 100
Zi.	ysiciar is certif directo	o Be	25. Was case referre examiner? 1 ☐ Yes 2 ☐ N		Hospital:	Inpatient 2	☐ ER/Outpatie	nt 3 DOA Oth	ar:	Death (Check only	_	Other (Specif	Assisted
ion of	nding Physath. r: After this e funeral di	ation: T	27. Manner of Death 1 Natural 2 □ Accident	5 ☐ Pending investigation	28a. Date (Mon		28b. Time o	f 28c. Injui Wor			how injury oc		Living
Divis	tal or Atters safter deg	Certification: To	3 ☐ Suicide 4 ☐ Homicide	6 Could not b	e 28e. Place buildi	of Injury - At ing, etc. <i>(Spe</i>	home, farm, str	eet, factory, office		28f. Location City or To	(Street and Nu wn, State)	umber or Rura	al Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Medical (29a. Certifier (Check only one)	Certifying Pt	mîner: On the b	e best of my k pasis of exami ner stated.	nowledge, deat nation and/or in	h occurred at the tivestigation, in my	me, date and plopinion, death o	ace, and due to the	e cause(s) and , date and pla	d manner as s ce, and due to	stated. o the cause(s)
	To t with To t	Σ	29b. Signature/and ti	tle of certifier	1 1			29c. Licens	e number		. / i	gned (Month,	Day, Year)
			30. Name and addre	ss of person who	completed caus	Qui	em 23a) (Type	Print)	23.38		8191	10	
			TASNEE	n (Ai	CHAN	nu)	2835	SmiTH	AVE,	SUITEZ	03,	BAU	m) 21208
	Sta Registr	_	31. Date filed (Month	G 1 9 201	10 1	Registrar's Sig	nagire Apa	ale			,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25971 State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 Westlev Kem Creque August 11:19 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye June 29 **Funeral** 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign · 1969 Hours 1 ፟፟ M 2 □ F New York 117-56-4688 **Director** 41 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b County Director 10a. State 10c. City, Town or Location 1 Yes 2 No Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1325 Gold Meadow Way 21040 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Yes 2 No 1

Never Married 2 ☐ Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Furniture Distribution Warehouse Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Roberto (unk) Creque Alethia (nmn) Jakes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rhonda C. Watkins / Fiancee 1325 Gold Meadow Way, Edgewood, MD 21040 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal fr Bakers Cemetery 4 ☐ Donation 5 ☐ Other (%pecify) 8-18-10 Aberdeen, Maryland 21. Signal r of Funera 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final & Sovere Dilated Cardiomyo Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 2 🗆 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Investigation
6
Could not be 1 Yes 2 No ☐ Accident ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completed filled Medical 1 🔀 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check e cause(s) and maining 29d. Date signed (Month, Day, Year) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PLUMTREE Rd, BEL Joseph 208 31. Date filed (Month, Day, Year) 32. Reg State Registrar

			1- State of Maryland / [Registrar		irtment of Healt tificate of Deal		Hygier Reg. N	72 (1 (1)	25972	
e	Physici /Medic		1. Decedent's Name (First, Middle, Last) Patricia		Driever	2. Date o Month	Death	Day Year 2010	3. Time of Death	
1-1	Examin		4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital 5. Social Security Number 6. Sex 1		Baltimore City If Under 1 Year If Under Months Days Hou	y nder 24 Hrs. 8. Date o	Birth Day, Year	r) Cou	place (State or Foreign	
	Director		Usual Residence of Decedent	Yrs.		Jan 2	19	63 Mar	yland 10d. Inside City Limits	
	he Marylar 28a-f shov btified at	Director			inster		100 (Ditizen of What Cou	1 Yes 2 No	
	23a or 3		10e. Street and Number 1229 Deer Park Road		10f. Zip-Code 2115	57		U.S.A.	Titay .	
036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. It has the marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:		Vas Decedent of Hispanio f Yes, specify Cuban, Mex ☐ Yes 2 🛣 No Spe	c Origin? (Specify Yes or xican, Puerto Rican, etc. ecify:	No-	14. Race - Amer Black, White Specify: Wh		
21215-0036	ithin 72 ho ne. nan "natura nadical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	(Give I	dent's Usual Occupation kind of work done during DO NOT use retired) Secretary	most of working	16b	16b. Kind of Business/Industry Medical		
	e filed within al Hygiene. I other than ' vent, the Me		17. Father's Name (First, Middle, Last)			Mother's Name (First, Mi	ddle, Maic			
Maryland	should be and Mental marked o	To Be	Harry E. Thompson, Sr.			Ruth D		7 7 7	in Ondal	
Mar	id 2 sho Ith and 27 is m traum				ng Address (Street and No Walnut Avenu				21117	
Baltimore,	Pages 1 and 2 nent of Health ant: If item 27 ary or other tra		20a. Method of Disposition 20b. Place of Cemeter 2 Removal from State	of Dispo	sition (Name of natory or other place) ts Cemetery	Date	20c.	Location - City or		
Balti	permit. Pages Department of Important: If i any Injury or o		21. Signature of Funeral Service Licensee		. Name and Address of FINE FUNERAL			erstown E own, MD	Road 21136	
100	Physician	s W	23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition in the cause of the c				ory arrest,		Approximate Interval Between Onset and Death	
1	/Medical Examiner		disease or condition resulting in death) a. Due to (or as a consequence antico as with	of):	9	,				
	ed sit	Examiner	Sequentially list conditions, if any, feating to the cause. Enter Underlying Cause (Disease or injury Disease)	of):						
8760,	cate be executed physician and s the burial-transii	edical Exa	that initiated events resulting in death) Last C. Due to (or as a consequence of the control of	e of):	9					
Box 6	ath certifi ittending for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ☑ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown		Ectopic pregnancy Other (specify)			23d. Date of del Month	very Day Year	
ds, P.O.	w requires that the de been signed by the a should be detached	by	Part II. Other significant conditions contributing to death but not resulting	in the u	underlying cause given in		Oid tobacc		the cause of death?	
I Records,	The law requate has been page 2 shou	Completed				6	Vas an autopsy performed es 2 🗜	prior to death?	topsy findings available completion of cause of 2 \square No	
Vita	Physician: The this certificate aral director, pa	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/O	utnatien	Othor	Place of Death (Check of Death		6 ☐ Other (Spec	ifv)	
Division of Vital	IIng Phys T. After this funeral d	ition: To	27. Manner of Death 28a. Date of Injury 28b.	. Time of Injury		28d. Desc		6 ☐ Other (Specify) njury occurred		
Divis	P 등 등	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, fa building, etc. (Specify)	arm, stre	eet, factory, office		on (Street Town, Sta	t and Number or Ro ate)	ural Route Number,	
	To the Hospital or Attenc within 24 hours after death To the Funeral Director: , completely filled in by the	edical C	29a. Certifier (check only one) 1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination are and manner stated.				time, date	and place, and du	e to the cause(s)	
	To th Withir Comp	Me	29b. Signature and title of certifier Cristine & Barry, M.D.	,	RES OU			Date signed (Month		
、レ	X		30. Name and address of person who completed cause of death (Item 23a)) (Type,		600 North	Wolfe	St, Baltimo	ore, MD, 21287	
	Sta Regist		31. Date filed (Month, Day, Year) AUG 1 9 2010 32. Registrar's Signature	. 19	bark			<u> </u>		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year OBERT 0035 M UGUST Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BAUTIMORE JOHNS HOPKINS BAYVIEW HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F (Month, Day, Year) 45 Director 215-86-4065 Usual Residence of Decedent 3a or 28a-f shov t be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director Baltimore MD NΑ XX Yes 2 No 10e. Street and Number 10f. Zip Code ral", or items 23a or Examiner must be n 10g. Citizen of What Country? Funeral 1735 Guilford Avenue 21202 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Armed Forces?
1 Yes 2 No Black, White, etc. African Completed by 1 X Never Married 2 Married 1 Yes Maryland 21215-0036 1 Yes 2X No Specify: Specify: American 3 Divorced Year or Dates art of Health and Mental Hygiene.

If item 27 is marked other than "natur or other traumatic event, the Medical [15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Spring Grove Elementary/Seconday (0-12) College (1-4 or 5+) 11th Grade State Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Robert L. Dendy, Sr. Shirley Dendv 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jannie Catherine Brown 1220 Bentalou Street Baltimore, MD 21216 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite any injury or ot King Mem. Pk. XBurial 2 ☐ Cremation 3 ☐ Removal from State 08-19-10 Randallstown, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Lice 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, MD Part 1. Enter the disease, or competcations that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SEVERE disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner PUANCED ALDS CONDARY Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi the Hospital or Attending Physician: The law requires that the death certificate be executed DISSEMINATE that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical NCYTOPENIA Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Year Day 1 Yes 2 No Pregnant at time of death Other (specify) g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an after death.

Director: After this certificate has I Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 2 No. ၉ 1 🗌 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 1 Natural 5 Pending 2 🗆 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined e Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c, License number 29d. Date signed (Month, Day, Year) RES-000 AUGUST 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Agnes Mwakingwe, M BALTIMORE, MO

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	Otato of Ma	ii y iai ia		ificate of D		mornar riy	Reg. No.	010	25974	
	Physicia	ın/	1. Decedent's Name (First, Middle, Last,)					2. Date of De	ath	Year	3. Time of Death	
-	Medic	cal	Gloria G. Davis 4a. Facility Name (if not institution, give s	etraat and number)			45 City Taylor an	Landin of Dan	August			08:10 a.м	
	Examin	ier	Tate Hospice Hous				4b. City, Town, or Linthic		ın		4c. County of Death Anne Arunde1		
	uneral		5. Social Security Number 6. Sec		(In yrs. last l		If Under 1 Year Months Days	If Under 24 Hrs Hours Min		th	O Dieth	wlass /Ctate or Faurier	
144	oirector		213-14-2248 Usual Residence of Decedent		89	Yrs.			07/28/	[921		ntry) Maryland	
land	f show	tor	10a. State 10b. County		10c. City, To	own or Loca	ation					10d. Inside City Limits	
e Mary	r 28a- notifie	Jirec	Maryland Anne Aru	ndel Co.	Sev	erna :						1 ☐ Yes 2 🛣 No	
/ith the	23a or st be i	ral	10e. Street and Number 715 Benfield Roa	ad			10f. Zip Code 2114				en of What Cou		
eath v	tems er mu	Funeral Director		12. Was Decedent Ev	er in U.S.	13. W	as Decedent of His Yes, specify Cubar		Specify Yes or No-		nited S [*] 4. Race - Ameri		
urs after d	Department or neutrin and wenter progene. Department or neutrin and wenter progene. By any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates.	lo		Yes, specify Cubar □ Yes 2 ∏ No		to Rican, etc.)		Black, White,		
hours	'natur dical I	olete	15. Decedent's Edi (Specify only highest grad	ucation	1		nt's Usual Occupa		and discount	16b. Kind	W.D.: d of Business Ir	ite	
thin 72	than the Me	Completed	Elementary/Seconday (0-12)	College (1-4 or 5+		life. DO	nd of work done d NOT use retired)	-			ltimore		
N per	other ent, th	(a)	12 yrs. 17. Father's Name (First, Middle, Last)		ĮSt	uperv	isor Cent		ords Dep ame (First, Middle,			e Department	
d be fi	viental srked itic ev	욘	Joseph Gentile						ide Emm		•		
shoule	is me		19a. Informant's Name/Relationship (Typ				Address (Street a						
and 2	em 27		Mr. Roland J. Davi	is, Jr. /S			Brassie	Court	Chesape				
age 1	ont: If it		1XXSurial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		ceme	etery, crema	atory or other place	1	Date		ation - City or T		
rmit. P	Importar Importar any injur	3	21. Signature of Funeral Service License		<u> Parkv</u>		Cemetery Name and Addres	: U8/ s of Facility Si	<u>21/</u> 2010 ngleton	Funer	al & Ci	Maryland remation	
a 82	2 = 6	j. I	Mile.		01121	Sei	cvices PA	1 2nd	Ave. SW	; G1e	n Burn	ie, MD 21061	
			23a. Part 1. Enter the disease, or compl shock, or heart failure. List only one Immediate Cause (Final	ications that caused to e cause on each line.	the death. D	o not enter	the mode of dying	, such as cardia	c or respiratory ar	rest,		Approximate Interval Between Onset and Death	
	sician, Iedical		disease or condition resulting in death)	a. Due to (or as a	Consequence	100	3-6010	*			\rightarrow	Onset and Death	
Exa	aminer		0	Buo to (or up u	oonocquene	, o oi).							
70	##	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequenc	e of):							
ecute	and I-trans	Exan	Cause (Disease or limiting that initiated events resulting in death) Last	Due to (or as a	consequenc	e of):							
ificate be executed	physician and the burial-transit			d.									
	g Sg	Medical	IF FEMALE:										
ath cer	ed by the attendin detached for use	Physician/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 ☐ Live Birth 2 4 ☐ Pregnant at t	☐ Fetal de		Ectopic pregnancy Other (specify)	,		23	d. Date of deliv	very Day Year	
he de	y the a	hysic	1 Yes 2 No 9 Unknown	9 Unknown	ume or dead	II Ş 🗆	Other (specify)						
s that	gned b	by P	Part II. Other significant conditions cor		t not resultin	in the und	derlying cause give	en in Part I.			,	he cause of death?	
equire	s been signe should be	eted	(Jar 103-24), 10		x he	4-14-4	100+N	<u></u>		Yes 2 🖼		bably 4 Unknown	
Attending Physician: The law requires that the death cer ar des th.	has le 2	Completed	Cardine Di	Sels				·-·	24a. Was autor perfo	osy rmed2	prior to co death?	opsy findings available ompletion of cause of	
an: ⊥h			25. Was case referred to medical				26. Pla	ce of Death (Che	1 🗆 Yes	2 No	1 🗆 Yes	2 🗌 No	
hysici	this cer al direc	욘	1 L Yes 2 L No	lospital: 1			3 DOA Other	4 🗌 Nursing I	Home 5 Resid	dence 6 🗹	Other (Specifi	Hospice How	
ding P	≽ è	ate:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of injury (Month, Day,		o. Time of injury	28c. Injury work? M 1 🗆		28d. Describe h	ow injury o	ccurred	3	
Atter	oy the	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury	/ - At home,	farm, stree		es 2 L No	28f. Location (S	Street and N	lumber or Rura	l Route Number,	
tal or	al Dire	ဦူ	4 E Honicide determined	building, etc.	(Specify)				City or Tow			·	
Hospi 24 hou	To the Funeral Director. After completed filled in by the fun	Medical	29a. Certifier Check 2 Medical E Min	in: To the best of mer. On the basis of exa	mination and	d/or investig	ation, in my opinior	, death occurred	at the time, date a	nd place, an	nd due to the ca	use(s) and manner stated.	
To the within	То the compl	Σ	29b. Signature and title of certifier	PERSONAL TO THE DE	AND THE REAL PROPERTY.	Williagh, De	29c. License		ace, and bue to the		signed (Month,		
			() () Ph	11			(6)	3/5		Ang	ist 1	62010	
			address of person who co	mpleted dea	th (Item 23a	a) (Type, Pri	the H	coil.	1 Dry	4 6	Linken	V (/10/2)	
	Stat	e	31. Date filed (Month, Day, Year)	32 Registrar's	s Signature	74	110	Sorte	1 0	1) 1	MINDUI	1 4 100	
F	Registra		AUG 1 9 2011	1 Amus	1 1	Ma	Mad						

		4	State of Maryland / Department of Health and Mental Hygiene 1 - State Certificate of Death Reg. NO 0 1 0 2 5 9 7 5							
			Registrar 1. Decedent's Name (First, Middle, Last)			<u>outr</u>	2. Date of Death	2010	3. Time of Death	
	Physicia: Medic	n/ al	Julia Joseph	ine Doyle			Month Au	g 14, 2010 ^{Yea}		
	Examin		4a. Facility Name (if not institution, give street and number) 6840 Norris Lane		4b. City, Town, or	Location of Death Elkridge		4c. County of De	eath Howard	
	Funeral Director	5	5. Social Security Number 219.10.4527 6. Sex 1 D M 2 F 7. Age (In	yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jun 8	9. l 9. 1 923	Birthplace (State or Foreign Country) MD	
		-	Usual Residence of Decedent 10a State 10b. County 10	c. City, Town or Lo	estion				10d. Inside City Limits	
	taryland Ba-f sho tified at	ector	MD Howard	ic. City, Town or Lo	cation	Elkridge		1 🗆 Yes 2 🗶 No		
	ith the N 23a or 24 st be not	Funeral Director	10e. Street and Number 6840 Norris Lane		10f. Zip Code	21075	1	0g. Citizen of What (Country? J.S.A.	
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatte event, the Medical Examiner must be notified at once.	ক্র	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.		Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 2 No	Specify:	Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: 6b. Kind of Business Industry		
21215-0036	nin 72 ho ne. han "nat e Medic:	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+)	(Give	dent's Usual Occupa kind of work done d O NOT use retired) hon	luring most of work	sing		t home	
and 21	e filed within and Hygiene. ed other than event, the M	as la	17. Father's Name (First, Middle, Last) Francis W. Per	ach		18. Mother's Nan	laiden Surname) ma McDonn	ell		
Maryland	2 should b th and Mer ?7 is mark traumatic		19a. Informant's Name/Relationship (Type, Print) Edward V. Doyle Spouse	19b. Maili 684	ng Address (Street a 0 Norris Lan	and Number or Rui e Elkridge,	ral Route Number, MD 21075	City or Town, State,	Zip Code)	
Baltimore,	Page 1 and nent of Healint: If item 2 iny or other		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Cther (Specify)	20b. Place of Dispo cemetery, cree St. Jo	osition (Name of matory or other place hn's Cemetery	e) Au	Date g 17, 2010	20c. Location - City Ellic	ott City, MD	
Balti	permit. I Departm Importa any inju		21. Son Jure Funetal Surce bensee							
	Priysician/ Medical Examiner	al Examiner	23a. Part is Enter the disease, or complications that chused the shock, or heart failure List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last 2a. Due to (or as a complete cause) D		Approximate Interval Between Onset and Death I mowths					
P.O. Box 68760	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	☐ Fetal death 3 ime of death 5	☐ Ectopic pregnand ☐ Other (specify) underlying cause gi		1		Day Year te to the cause of death?	
Division of Vital Records,	ician: The law requires that the certificate has been signed by thector, page 2 should be detach	Completed b					1 🗌 Yes	an 24b. Wer sy prio med? dear	□ Probably 4 □ Unknown e autopsy findings available r to completion of cause of th? Yes 2 □ No	
tal	ysician: 1 is certifica director, p	Be	25. Was case referred to medical examiner?		LOU	lace of Death (Che			2	
of Vi	ng Phys fter this ineral dii	ate: To	1 Inpatient 2 ER/Outpatient 3 DDA 4 Nursing Home 5 Decision 6 Other Specify							
visior	of or Attendi after death. Director: A d in by the fu	Certificate:	2 Accident 3 Suicide 4 Homicide Investigation 6 Could not be determined 4 Homicide Action (Specify) At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)							
Ö	To the Hospital or Atter within 24 hours after de To the Funeral Directo completed filled in by th	Medical C	29a. Certifier 1 Certifying Physician: To the best of m (Check 2 Medical Examiner: On the basis of examiner)							
	To the h within 24 To the F complet	Me	only one) 3 Certifying Nurse Practioner: To the be	est of my knowledge	, death occurred at t	ne time, date and p	lace, and due to the	e cause(s) and main	el as stated.	
			29b. Signature and title of certifier Clause G. Scale 30. Name and address of person who completed cause of det Educated A. Scale Suit 31. Date filed (Month, Day, Year) AUG 19 2010	ath (Item 23a) (Type	Print)	275	5110	SKR.1	I. MD200	
12			31, Date filed (Month, Day, Year) 82. Registrar	's Signature	ruc F	r UU>.	overm	09 1041	w. raw	
	Sta Regist	ate rar	AUG 1 9 2010 dans	1. 40	Mad					

				partment of Health and N	/lental Hygie	ne	
				ertificate of Death	Reg	. No 20 0	25976
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year	3. Time of Death
	Medic	al	Dorothy Velma Force 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	August	Day 16 201	
-4	Examin	er 	Tate Hospice House	Linthicum He		4c. County of Deat	Arundle
	Funeral Director		5. Social Security Number 218-22-5345 6. Sex 1 \square M 2 \square VF 7. Age (In yrs. last birthda	Months Days Hours Min	8. Date of Birth (Month, Day, Ye Feb . 11	9. Bir Co	thplace (State or Foreign puntry) PA
	od Jow at	_	Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or	Location			10d. Inside City Limits
	larylar ta-f sl ified	Director		erna Park			1 ☐ Yes 2 🔀 No
	or 28 e noti		10e. Street and Number	10f. Zip Code	10g	. Citizen of What Co	ountry?
	with s 23a rust b	Funeral	67 Robinson Landing Road	21146		USA	
	death item ner m		Armed Forces?	Was Decedent of Hispanic Origin? (Spetf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
36	after al", or xami	d by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No If Yes, Give Vegr or Dates	1 ☐ Yes 2 ☐ Wo Specify:		Specify:	White
21215-0036	within 72 hours after death with the Maryland giener trinen "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at the Medical Examiner must be notified at	Completed by	15. Decedent's Education 16a. De	cedent's Usual Occupation	16	b. Kind of Business	Industry
212	in 72 ie. han "i	dwo	Flomenton/(Seconday (0.12) College (1.4 ex.5.) life	ve kind of work done during most of work DO NOT use retired)	ing		•
2	d with fygien ther tl nt, the	Be C	9th 17. Father's Name (First, Middle, Last)	stodian		Cleani	rng
Maryland	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mertal Hygiene. If Health amarked other than "tratural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	To B	Joseph L. Powell		e (First, Middle, Maid a Powell	,	
lary	should and Me is mar raumati			ailing Address (Street and Number or Rura	, ,		,
	and 2 Health em 27 ther tr			7 Robinson Land		c. Location - City or	
Baltimore,				rematory or other place) EW Crematory 8/1	7/10	Baltimo	
Balt	permit. Page Department Important: It any injury or once.		21. Sign tury of Fineral Statice Licensee	22. Name and Address of Facility 30 Connelly Funera			
П			23a. Part 1. Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac c	or respiratory arrest,		Approximate Interval Between
~	h_sician/	X I	Immediate Cause (Final disease or condition	age Heart Disea	se		Onset and Death
	Medical Examiner		resulting in death) Due to (or as a consequence of): Due to (or as a consequence of):	ege Heart Disea			
	- ±	iner	if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):	3			
	ate be executed physician and the burial-transit	Examiner	Cause (Disease or iinjury that initiated events c				
09	s be ex sician e buria	dical	d				
9/89	certificate be nding physici use as the bu	Med	IF FEMALE:				
×	th cert ttendii or use	ian/	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death			23d. Date of de	livery Day Year
Box.	the death or the atternation of the atternation of the atternation of the atternation of the control of the con	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 ☐ Other (specify)		Month	Day Teal
9, P.O	law requires that the death certifics has been signed by the attending p ? 2 should be detached for use as :	Completed by Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.		4	the cause of death?
org	requir been should	ete	Chroni atrial fib		24a. Was an		itopsy findings available completion of cause of
Ş Ş	The law cate has page 2 s	omo	Ducenousa		autopsy performed 1 \(\sum \) Yes 2 \(\overline{4}\)	d? death?	completion of cause of s 2 □ No
g	ian: T ertifica ctor, p	Be C	25. Was cas referred to medical	26. Place of Death (Check		110	2 2 1 10
5	Physician: The this certificate al director, pag	ပ္	1 Yes 2 No No No Nopital:		me 5 🗆 Residence	e 6 Other (Spec	city) Hospine
Division of Vital Records,	nding F ath. :: After i	Certificate:	27. Manner of Death 1 ✓ Natural 5 □ Pending 2 □ Accident Investigation 28a. Date of injury (Month, Day, Year) 28b. Time injury		28d. Describe how in	njury occurred	
VISIC	r Atter ter des irector by th	ertifi	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, St	t and Number or Rui	ral Route Number,
ā	pital o			the appropriate the time and the said of t			
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific completed filled in by the funeral director,	Medical	(Check 2 Medical Examiner; On the basis of examination and/or inv	estigation, in my opinion, death occurred at	the time, date and pl	lace, and due to the	cause(s) and manner stated.
	North Con		29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month	h, Day, Year)
			forwed attanasio no	D-28097		8/16/1	0
			30. Name and address of person who completed cause of death (Item 23a) (Type Physical Arrayasio 9114 Ph	eledienha Rd	Stute 100	8 . Balt	, Md. 21237
	Stat		31. Date filed (Month, Day, Year) 32. Kegistrar's Signature	e, death occurred at the time, date and place 29c. License number 0 - 28097 e, Print) Ladelphia Rd-			,
-94	Registra	ir	AUG 1 9 2010 Laneva B. A	Par			

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 6:15 4a. Facility Name (If not institution, give street and number) 2010 /Medical 4b. City. Town or Location of Death 4c. County of Death Examiner WHO Howard 2625 laise 0 24 Hrs. Year If Under Date of Birth (Month, Day, Year) 7/20/1929 Birthplace (State or Foleign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min M 2₹ F Yrs. PA 166-28-2561 81 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show ral", or items 23a or 28a-f shov 1 ☐ Yes 2X No Director Woodbine Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21797 USA 2625 Daisy Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 222100 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married XX Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 Tyes 200000 Specify: Specify: þ White 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) **5+** Journalist/Editor Baltimore Sun other i 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be filk tment of Health and Mental H tant: If item 27 Is marked oth Be Clara Craddock James Purvis မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Hugh E. Flaherty/Husband 2625 Daisy Rd., Woodbine, MD 21797 permit. Pages 1 and Department of Healt Important: If item 2: any Injury or other: once. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Crematory 8/21/2010 Winfield, MD 21. Signature of Funeral Service Ligense ²² Name and Address of Facility Burrier-Queen Funeral Home & Crematory, P.A. ann 1212 W. Old Liberty Rd., Winfield, MD 21784 er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Part 1. Er Imme Inter ause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transi resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23c. If ves. outcome of pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea: 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown detachi 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 ☐ Yes 2 ☐ No 3 ☐ robably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury Natural 5 Pending investigation 1 ☐Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Direc 4 Homicide filled in within 24 hours a To the Funeral D trifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 3010 00580 Name and address of person who completed cause of death (Item 23a) (Type, Print) eneshiour 60 वा उड 62. Registrar's Sign State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

alvin Loy Fidler Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10-03398 State of Maryland / Department of Health and Mental Hygiene UNK-UNK 1- For State Certificate of Death Registrar 2. Date of Death Physician/ 1. Decedent's Name (First, Middle, Last) Month 0935 hrs May 3, 2010 **Medical Examiner** Calvin Loy Fidler 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel Pasadena 94 Ritchie Highway S. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Country) Hours Months Days 10/07/1955 Director Washington,DC 54 1XXM 2 F 214-66-0175 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location any 10a. State 1 Yes 2 X No Pasadena Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. Anne Arundel Co. MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21122 94 Ritchie Highway S, Apt. 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1XX Never Married 2 Married Yes White Yes 2X No specify: Specify Give Year 3 Widowed 4 Divorced \$ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) N/AUnemployed 12 yrs. 18.Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Palm Virginia Donald Fidler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Burlington, KY 5493 Carry Back Drive Mrs. Erin Frederick / Sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery Date 20a. Method of Disposition crematory or other place) 1 Burial 2 A Cremation 3 Removal from State 08/19/2010 Glen Burnie, MD Atlantic Crematory Donation 5 Other Specify. 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licenses MO1121|Services, PA; 1 2nd Ave. SW; Glen Burnie, MD 21061 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause of each line /Medical Death a Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical AMENDED UNPENDED e attending physician for use as the burial -Box 68760. 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Month Day Year 3 Ectopic pregnancy Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o ۵ 1 Yes 2 No 3 Probably 4 V Unknown Δ. Completed Records. 24a. Was an 24b. Were autopsy findings available After this certificate has been prior to completion of cause of autopsy death? page 2 Yes 2 ✓ No 2 No Yes 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be examiner? Other: A Nursing Home 5 Residence 6 Other: Scene DOA Inpatient 2 ER/Outpatient 3 ٩ 1 V Yes No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: 1 V Natural 1 Yes 2 No 5 Pending To the Funeral Director: within 24 hours after death. 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be 3 Suicide or Town, State) determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number May 4, 2010 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Pamela E. Southall, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2010 Registrar OCIVIE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** GRIPPER 2010 08 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death **Examiner** LORIEN NUNSING 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 F Director NORTH CAROLINIA 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director 10e. Street and Numb 10f. Zin Code 10g. Citizen of What Country? Funeral Was Decedent Ev. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 11 Marital Status edent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygienc Important: if item 27 is marked other tha any ly lipry or other traumatic event, the once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GEORGE GREEN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ARDOW'T CROWN HAY 21. Signature of Funeral Service Lice /u 23a. Part1. Enter Ind disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Vay **Physician** FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HEART FAILURE ONGEST, VE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that the death certificate be executed DEMENTIA onetro STA GE that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician a for use as the burial-t Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) __ in the past 12 months? Month Year 4□Pregnant at time of death 0 ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ hypertens, on 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an as) autopsy performed ate a 1∐ Yes 2 □100 certifi 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: Nursing Home 5 Residence 6 Other (Specify) 20 No 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA o After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Hospital or Attending Natural Iniury 5 Pending within 24 hours after death.

To the Funeral Director; A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00053150 AUG 10 2010 30. Name and address of person who completed cause of death (item 23a) (Type, Print) SUITE 110 9650 SANY, AC, O SHAWNMALA COLUMB, A

DHMH 17 Rev 1/2001

Registra

31. Date filed (Month, Day, Year)

AUG 1 9 2010

ND 21045

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 0 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Guseino**v**a Fazila 08 2010 10:00p M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4315 Labyrinth Ave Apt Baltimore 18 If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign (Month, Day, Year) 01 23 1 M 2 X F Director 217-73-6434 Georgia 87 Usual Residence of Decedent f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho. 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD NA 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 Georgia 4315 Labyrinth Ave Apt 1B 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced Completed White Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Home 6th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ permit. Page 1 and 2 should be to Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en Ziya Hurushanon Gokche Hurushanova 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215 4315 Labynith Road Apt 1-B Baltimore, <u>Bakhtiyar Gusenov-Son</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) King Memorial Park 8/13/2010 Woodlawn, Md 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Cardiovascu Atheroscleron disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to for as a consequence of,: if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Year Pregnant at time of death Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Cerebro vascula 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 🗌 Yes 2 🗆 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: Certificate: To 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred in 24 hours after death.
the Funeral Director, After a function by the function of the functin Natural 5 Pending 2 Accident 1 🗀 Yes 2 🗌 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and tith of certifier 29d. Date signed (Month, Day, Year) D0033897

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year

3700

St Baltimere

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32 Registrar's Signature

		,	For State Registrar	State of M	Maryland		artment of F ctificate of t				jiene eg. N20	10	25981
			Decedent's Name (First, Middle, La	st)			tinoato or .	<i>-</i>		Date of Dea	th		3. Time of Death
	Physici /Medic		Donald A.		Gries	er, Sr			Αι	Month 1g. 15	, ^{Day}	Year	7:32 P M
	Examin		4a. Facility Name (If not institution, give				4b. City, Town, or	r Location of			4c. Count	y of Death	
			Anne Arundel Medi				Annapo1		D4 Hea Ta	D 1 (D: 11		Arur	
	Funeral Director		1/9-10-0653	Sex 7. A	Age (In yrs. Ia 87	Yrs.	Months Days	Hours	Min.	Date of Birth (Month, Day or • 13	Year) 1923	9. Birthi Cour Penn	place (State or Foreign ortry) sylvania
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City,	. Town or Loc	cation					1	0d. Inside City Limits
	Maryl Fsho	tor	Maryland Anne Aru	ınde 1	Ede	ewater							1 □Yes 2 No
	h the	irec	10e. Street and Number			0,,,,,,,,,	10f. Zip Code			1	0g. Citizen of	What Cour	ntry?
	23a c	Funeral Director	3609 Fontron Dr.				2103	7			United	Stat	es
	tems	nne	11. Marital Status	12. Was Deceden Armed Forces	3?	i. 13. V	Vas Decedent of H f Yes, specify Cuba	lispanic Ori an, Mexicar	igin? (Specif n, Puerto Ric	y Yes or No- an, etc.)		ce - Americ	
036	urs afte al", or i	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 XXYes 2 ☐ If Yes, Give Year or Dates		1	□Yes 2X No	Specify:			Specia	√ Whi	.te
2-0	72 ho	Completed	15. Decedent's Ed (Specify only highest gra	ducation	1		lent's Usual Occup		t of working		16b. Kind of B	Business/In	dustry
121	/ithin ine.	mpl	Elementary/Secondary (0-12)	College (1-4or	r 5+)	life. E	ssblower	d)	t or working		NT		
75 D	filed w Hygie ther t	ပိ	17. Father's Name (First, Middle, Last,	''		Ста	ssblower	18 Mothe	ar's Name <i>(F</i>	irst Middle	Neon Maiden Surnai		
altimore, Maryland 21215-0036	should be filed within 72 hours after death with the Maryland ind Mental Hyglene. I marked other than "natural", or items 23a or 28a-f show in matic event, it is likedical Examiner must be notified at	To Be	Henry F. Grieser						,	binski		,,,,	
Mary	d 2 sho th and 7 Is ma trauma		19a. Informant's Name/Relationship (Sharon Lee Bolick	**	·or	l	g Address (Street . Fontron			water.		, State, Zip 21037	,
ē,	tem 2		20a. Method of Disposition	, baagii			sition (Name of natory or other place		Date		20c. Location		
m 0	Pages ment of ant: If i		1 N Burial 2 □ Cremation 3 □ 4 □ Conation 5 □ Other (Specific		e		en Mem. P		3/19/20	010	Glen Bu	ırnie	MD
Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Dipartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is healtes Examiner must be notified at once.		21. Signature/of Funeral Service Liver	nsee MO	1270	22	. Name and Addres irkley-Ru 21 Crain	ss of Facilit	ty				21061
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that cause	ed the death.	Do not ente	er the mode of dyin	ng, such as	cardiac or re	espiratory arr	est,	ĽШ	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	one cause on each		Fard	ial in	1	·cx	mi			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	s co seque			1					
		ja	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	s a conseque	ence of):						-	
	d d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	240 10 (01 4		01100 017.							
Ŏ,	e exectian an	Exa	resulting in death) Last	Due to (or a	s a conseque	ence of):							
38760,	ficate be executed physician and s the burial-transit	dical	•	d									
Box	death certifi e attending d for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom							23d. Da	ate of delive	erv
	0 0 0	Physician/Me	in the past 12 months? 1 ☐Yes 2 ☐ No 9 ☐ Unknown	1 □ Live birth 4 □ Pregnant 9 □ Unknown	at time of de		Ectopic pregnancy Other (specify)	у				onth	Day Year
o.	signed by		Part II. Other significant conditions of	ontributing to death	but not result	ting in the un	derlying cause give	en in Part I.	.	23e. Did to	bacco use con	tribute to the	ne cause of death?
Vital Records,	law requires that the as been signed by the 2 should be detache	ted by							_	1 □ Y	es 2 No	3∏ Prob	pably 4 Unknown
3ec	he faw r has be ge 2 sh	Completed								24a. Was a autops	sy	prior to co	psy findings available mpletion of cause of
<u>-</u>	iclan: The certificate h ector, page										2 No	death? 1 ☐ Yes	2 □ No
5	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpai	tiont 2 DE	R/Outpatien	Othe	or:		heck only on			
	iding Physician: th. : After this certific funeral director, p	<u>ان</u> 1	27. Manner of Death	28a. Date of In	jury 2	28b. Time of Injury	28c. Injury	y at			ence 6 Otl		<i>y)</i>
010	Attending r death. ector: After by the fune	atio	1 Natural 5 Pending investigation	1	ay, rear/	mjary		Yes 2 □	No				
Division	l or Att after de Directe	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Ir building, e	njury - At honetc. <i>(Specify)</i>	ne, farm, stre	et, factory, office		28f.	Location (Si City or Town	treet and Num n, State)	ber or Rura	al Route Number,
:		Medical C	29a. Certifier (Check only one) Certifying Ph	ysician: To the bes niner: On the basis and manner s	of examination	rledge, death on and/or inv	occurred at the tir restigation, in my o	me, date ar pinion, dea	nd place, and ath occurred	d due to the d at the time, d	ause(s) and mate and place,	nanner as s and due to	tated. the cause(s)
	To the within To the somple	Mec	29b. Signature and title of certifier	and manner s	natou.		29c. License	e number		2	9d. Date signe		
			Yough to !	Mose	M	0	DI	63	76		08-	16-	2010
			30. Name and add 4s of person who	completed cause of	death (Item :	23a) (Type, F	Print).	1.		1		` ,	2010 D 21401
	CAN		31. Date filed (Month, Day, Year)	22. Regi	rar's Signatu	Med	hares	nfeu	voy,	Muc	Pali	×1/1/	1) 21401
	Stat Registra		AUG 19	2010	neva	A. ,	parke				V		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 for State Registrar 25982 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month August Year 5:00A M LEN GORDON 2010 Medical 4a. Facility Name (if not institution, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Windsor Court Bathmore 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs, last birthday, 8. Date of Birth 9. Birthplace (State or Foreign Days 1 M 2 X Hours Director 8-26-655 Country) Yrs 10a. State 10b. County be filed within 72 hours after death with the Maryland ortant: If item 27 is marked other than "natural", or items 23a or 28a-1 sho Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Windsor 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral allivar 744 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc ģ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other tranmeth. Baltimore Citu Elementary/Seconday (0-12) College (1-4 or 5+) Secretar th grade Punic Schools YEAVS Be 17. Father's Name First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည SCAV Talle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, State, Zip Code) Sullivan Court innette Windsor Daughte Mill MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) butus 21. Signature of Funeral Service Licensee 22. Name and Address of Facility aughn C. Greene Puneral 728 Liberty Loak Randallstown 23a. Part 1. Enter the di shock, or heart ail Immediate Cause (Final disease, or complications that caused the death. Do not enter the mode of dying, such as eardiac or respiratory arrest allure. List only one cause on each line. Physician/ Onset and Death Stenne disease or condition eromyo surcom Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): and -tran Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical signed by the at d be detached fo þ Completed

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 completed filled in by the funeral director, After this within 24 hours after deat To the Funeral Director:

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No g ☐ Unknown	23c. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	Be. Did tobacco use contribute to the cause of death?
		1 Yes 2 No 3 Probably 4 Unknown
		4a. Was an autopsy performed? ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner?	26. Place of Death (Check only or	
1 ☐ Yes 2 No	Hospital: 1	Residence 6 Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigat	28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work? M 1 ☐ Yes 2 ☐ No	escribe how injury occurred
3 Suicide 6 Could no 4 Homicide determine	28e. Place of Injury - At home, farm, street, factory, office 28f. Loc	cation (Street and Number or Rural Route Number, y or Town, State)
(Check 2 L Medical Exa	nysician: To the best of my knowledge, death occured at the time, date and place, and due to miner: On the basis of examination and/or investigation, in my opinion, death occurred at the time urse Practioner: To the best of my knowledge, death occurred at the time, date and place, and d	e date and place, and due to the cause(s) and manner state

Or leans

29c. License number

36986

37.

29d. Date signed (Month, Day, Year)

18, 2010

21231

State Registrar

Be

Medical Certificate: To

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

ack

1650

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Z 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 30 AM Gordon 20/0 August Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore City daryland General If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year 0 9 - 30 - 5 9. Birthplace (State or Foreign **Funeral** Hours Min. 1**x** x M 2 □ F 218-60-3742 57 Director MD Usual Residence of Decedent 10b. County 10a, State 10c. City, Town or Location at 10d. Inside City Limits e filed within 72 hours after death with the Maryland Director 28a-f must be notified NA Baltimore MD XX Yes 2 No 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 3719 Colborne Road 21229 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. African 1 Never Married 2 Married Yes 2 X No Yes, Give Completed by Maryland 21215-0036 1 Yes 2 No Specify: Specify: American 3 Widowed 4 Divorced Year or Dates other traumatia event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Restaurant 6th Grade Cook Be per it. Page 1 and 2 should re filed Department of Health and Mental Hy Important: If item 27 is mar ed oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Johnny Gordon Laura Venev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3026 E. Federal Street Baltimore, MD 21213 Shanee Randall-Niece Baltimore, 20b. Place of Disposition (Name of cemetery crematory or other place)
Mt. Zion Cem. 20a. Method of Disposition 20c. Location - City or Town, State 💢 Burial 2 🗆 Cremation 3 🗆 Removal from State 08-21-10 Lansdowne, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Functal Service License 22. Name and Address of Facility Wylie Funeral Home P.A. Street Baltimore, MD 638 N. Gilmor Part 1. Enter the disease, or complete ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart fallure. List only and cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ vere disease or condition Medical resulting in death) Due to (or as a consequence of) __________________Examiner Circho si Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) as the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 2 No 3 Probably 4 onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\subseteq \text{ Nursing Home } 5 \subseteq \text{Residence } 6 \subseteq \text{Other (Specify)} 2 1 No 1 Impatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury 28c. Injury at 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) 1 Anatural work? 1 \(\subseteq \text{Yes} 5 Pending 2 🗌 No Investigation Accident 3 Suicide
4 Homicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗗 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

GORVON

DHMH 17 Rev 7/2009

3 29b. Signature and title of certifier

31. Date filed (Mon

29c. License number

Maryland General Hospita

29d. Date signed (Month, Day, Year)

Amend Trem 123a per dr., good, hg/elib/2016 Tensure All Copies Are Legible. 1 - For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician OMM 2010 /Medical Examiner 1/5 town fromore 9. Birthplace (State or Foreign **Funeral** Phillipines Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show и items 23a or 28a-f shov 1 ☐ Yes 21 No Director Owings Mills Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with USA 21117 28 S. Ritters Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 72 hours after 1 ∐Yes 2 XINo If Yes, Give Year or Dates: 1 Never Married 2 Married white ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify þ traumatic event, the Medical Even 3 ₩ Widowed 4 Divorced natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) i 2 should be filed within 72 th and Mental Hygiene. 7 is marked other than "n College (1-4or 5+) Elementary/Secondary (0-12) teacher education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cecile Marie Robert Raymond Schulteis ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is n any injury or other traun once. 28 S. Ritters Lane; Owings Mills, Maryland 21117 Denise Harper - daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signal of Funeral Solice 22. Name and Address of Facility Board; 655 W. Baltimore Street S. Wade ector Baltimore, Maryland 21201 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat Cause (Final disease or andition resulting in eath) Physician /Medical Due to (or a a consequence Aspiration Pneumonia Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sate has been signed by the ettending physician and page 2 should be detached for use as the burial-transit be exect Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Pregnant at time of death 4 Pregnant 5 ☐ Other (specify) P.O. P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ۾ 2 NO 3 Probably 4 Unknown 1 🗆 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 certificate 1 ☐Yes 2 ☐No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: Hospital: 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Plospital or Attending Plant Plant Structure of Hours after death.
Funeral Director: After the structure of House Structure of Structure of House After t 1 Natúral 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Sign ture and title of certifier D25112 2010 completed cause of death (Item 23a) (Type, Print) Suite MD 2/11/ 30. Name and address of person who Drive 0 ads State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item 26 per dr.,g906,08/19/2010dhb

Gertificate of Death

Reg. No. 20 | 0 1 - State A Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) 4b. Oty, Town, or Location of Death **Examiner** 4c. County of Death Marrio tsville vad timore Security Number 6. Sex . Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗹 Months Days Hours Min. 1/Yrs. Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director A 1 Yes 2 No Hanove hanic 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23111 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ş 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: 3 🗆 Widowed 4 🗆 Divorced Completed 1ac Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. **P**O NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ mes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ľa 20a. Method of Disposition 20b. Placedkevs ew 20c. Location - City or Town, State Ďate 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Funeral Services Kanda 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause of each line. Approximate Interval Betweer Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (of as a consequence of). the attending physician and thed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Day Year Pregnant at time of death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the scompleted filled in by the funeral director, page 2 should be detached to 9 Unknown 9 Uhknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Probably 4 🗆 Unknown 1 Yes 2 No 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? perform 2 No Yes 2 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Daughter's Hospital Other: ျ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 N Hesidence 6X Other (Spec 28a. Date of injury (Month, Day, Year) 27. Manufer of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1. Natural 5 Pending Accident
Suicide Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d Bate signed (Month, Day, Year) 30, Name and address who completed cause of death (Item 23a) (Type, Print) per GA CROSSRUADS Dr. Ste 340 OWINGS MILLS, MD 21117 23 OUSUF MD 31. Date filed (Month Day, Year) State 2010 Registrar

	State Co	artment of Health and Mental rtificate of Death	7010 25900
	Registrar 1. Decedent's Name (First, Middle, Last)	2. Date of	Reg. No. of Death 3. Time of Death
Physician/ Medical	Norman Hall Harshman	Monti Augu	M
Examiner	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Funeral	1225 Aster Drive 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Glen Burnie If Under 1 Year If Under 24 Hrs. 8. Date of Months Days Hours Min. (Months Months Anne Arundel Co. of Birth On Birth Grant Social Grant	
Director	213-34-7537	World's Days Hours Will. 08/1	3/1937 Country) MD
land show d at	10a. State 10b. County 10c. City, Town or Lo	cation	10d. Inside City Limits
• Mary 28a-f notifie		Burnie	1 ☐ Yes 2 🖾 No
leath with the Maryland thems 23a or 28a-f sho er must be notified at Funeral Director	10e. Street and Number 1225 Aster Drive	10f. Zip Code 21061	10g. Citizen of What Country? U.S.A.
death vitems	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Specify Yes or f Yes, specify Cuban, Mexican, Puerto Rican, etc	r No- 14. Race - American Indian,
after or samir, or d by	1 ☐ Never Married 2 🔀 Married 1 🔀 Yes 2 ☐ No	1 ☐ Yes 2 🛛 No Specify:	Black, White, etc. Specify: White
5-0C hours haturadical E	15. Decedent's Education 16a. Dece	dent's Usual Occupation kind of work done during most of working	16b. Kind of Business Industry
2,1215-0036 (ithin 72 hours after claim "natural", or rithe Medical Examir Completed by	Elementary/Seconday (0-12) College (1-4 or 5+)	O NOT use retired) Insurance & Financial Planning	Insurance & Financial
nd 2	12 17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Mi	
ylan id be fi Mental marked attic ev	Harold Harshman	Gertrude	Ha11
Baltimore, Maryland 2,1215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inpopratn: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director		ng Address (Street and Number or Rural Route Ni 25 Aster Drive Glen I	umber, City or Town, State, Zip Code) Burnie, MD 21061
Ore, e 1 and c of Hez if item or othe	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition cemetery, crei	natory or other place)	20c. Location - City or Town, State
Itim iit. Pag artment ortant: injury o	4 Donation 5 Other (Specify) Atlantic	Crematory 08/19/201	
Bal- permit Depar Impor		2. Name and Address of Facility Singleto ervices PA; 1 2nd Ave S	SW; Glen Burnie, MD 21061
200	23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac or respirato	ory arrest, Approximate Interval Between Onset and Death
Ruysician/ Medical	Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):		Julia Diset and Death
Examiner	Sequentially list conditions, b. Pneumonia		2 weeks
xecuted n and sl-transit Examiner	in any, leading to immediate cause. Enter Underlying Cause (Disease or injury)		
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certificate: To Be Completed by Physician/Medical Exam	that initiated events resulting in death) Last C. Due to (or as a consequence of):		
760 cate be exphysician s the buria	d		
687 certific nding p. Lse as	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delivery
O. Box 68760 It the death certificate by the attending physicached for use as the by Physician/Medic	in the past 12 months?	Cther (specify)	Month Day Year
hat the ed by t detach	Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I. 23e.	Did tobacco use contribute to the cause of death?
ds, P. quires that signed and be did be did be did be did be did be did be did by the di			1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown
Records, The law require sate has been si page 2 should t	1		Was an autopsy autopsy findings available prior to completion of cause of
I Re n: The ficate by, page	25. Was case referred to medical	1 26. Place of Death (Check only one)	performed? death? Yes 2 🖫 No 1 🗆 Yes 2 🗆 No
Vital hysician nis certifi I director	examiner? 1	Out	Residence 6 Other (Specify)
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the stafer death. In Director: After this certificate has been signed by ed in by the funeral director, page 2 should be detacted by the funeral director, page 2 should be detacted by the funeral director.	27. Manner of Death 1 ☒ Natural 5 ☐ Pending 28a. Date of injury (Month, Day, Year) 28b. Time of injury	28c. Injury at work? 28d. Description	ribe how injury occurred
ivision of or Attending Por Attending Paffer death. Director: Affer tin by the funera	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, str		ion (Street and Number or Rural Route Number,
Divi	building, etc. (Specify)	City o	or Town, State)
he Hospita in 24 hours he Funeral pleted filled	29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge, death (Check only one) 3 ☐ Certifying Nurse Practioner: To the best of my knowledge,	tigation, in my opinion, death occurred at the time, o	date and place, and due to the cause(s) and manner stated
To the within To the comp	29b. Signature and title of Pertificial	29c. License number	29d. Date signed (Month, Day, Year)
	· semyxhusen chof	K118354	8/18/10
10 41	30. Name and address of person who completed cause of death (Item 23a) (Type, I 1900 Oak Point Ct Pasadena, MD	21122 HMy schuler	CLUP
State Registrar	29b. Signature and title of dertifier 30. Name and address of person who completed cause of death (Item 23a) (Type, F 1900 Oak Point Ct Pasadena, MD 31. Date filed (Month Day, Year) 32. Registrar's Signature	Red	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 3:30 AM Augus RAYMOND OSWALD HUFF 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death *itizens* Nursina Havre de Grace Harford 9. Birthplace (State or Foreign Country) Onio 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 1 🔀 M 2 🗆 F Days (Month, Day, Year Hours Min. Yrs Director <u> 283-22-9332</u> 82 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be norified any once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1911 Hawthorne Road 21040 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ⚠ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Completed 3 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Chemist U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Otis (unk) Huff Carrie (unk) George 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolores Huff / Spouse Hawthorne Road, Edgewood, Maryland 21040 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3X Removal from State 4 Donation 5 Other (Specify) Arlington National Cem. 9-14-10 Arlington, Virginia Signature of Funeral Service Licen McComas Funeral Home, P.A. 1317 Cokesbury Road. Abingdon MD 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner nomil Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No To the Funeral Director: After this certificate has been signed by the atte completed filled in by the funeral director, page 2 should be detached for I Month Day Year g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes Hospital or Attending Physician: 24 hours after death. 25. Was case referred to redical Be 26. Place of Death Check only one) 2 No Other: 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 \(\text{Yes} \) 2 🗌 No 2 Accident Accident Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) To the Hospital within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

avmen

16/13

M.17.

30. Name and address of person who completed cause of death (Item 28a) (Type, Print

4wD

31. Date filed (Month, Day, Year)

SIM

			For State	State of M	laryland		artmen <i>tificate</i>			and M			20	ın	2500
			Registrar 1. Decedent's Name (First, Middle, La	ist)		- 001	imoato	0, 2	Journ		2. Date of Dea	Reg. No.	20	-4	3. Time of Death
	Physicia		LEON]	HACK				AUGUS:	г ^{Дау}	Year 20	10	01:40A M
ute.	Medic Examir		4a. Facility Name (if not institution, giv	e street and number)			4b. City, Town, or Location of Death				4c. (County of De	ath		
10			GILCHRIST HOSPIC	E CARE .			TOT	WSON				В	ALTIM	ORE	
	Funeral			Sex 7. Ag 1 🛣 M 2 □ F	ge <i>(In yr</i> s. <i>I</i> a:		If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birt		9. E	irthpla o <i>untry</i>	ce (State or Foreign
	Director		220-12-9000	1 23 W 2 - 1		84 Yrs.					117037	1925			MD
	nd how at	=	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Loc	cation		-					100	I. Inside City Limits
	arylar a-fs ified	ectc	MD BALTIM	OPF	DTE	(ESVIL	T I								1 ☐ Yes 2 🛣 No
	he M or 28 e not	ä	10e. Street and Number	OKL	1 111	CLOVID	10f. Zip	Code			T	10g. Citiz	en of What (Country	/?
	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho er the Medical Examiner must be notified at	Funeral Director	8522 MEADOWSWEE	T ROAD			21	208							USA
	tems er mu	Ē	11. Marital Status	12. Was Decedent	Ever in U.S.	. 13. V	Vas Decede	ent of His	spanic Orig	gin? (Spe	cify Yes or No-	1	4. Race - An		Indian,
9	ter d , or i	2	1 Never Married 2 🛚 Married	Armed Forces?	No		Yes, speci			, Puerto I	Rican, etc.)		Black, Wh	ite, etc	.
21215-0036	urs at ural" al Ex	Completed	3 Widowed 4 Divorced	If Yes, Give Year or Dates.			Li fes 2	- NO	эреспу.	Annual of the second		s	specify: WI	HIT	E
5	"2 hor "nat	eg e	15. Decedent's l (Specify only highest g				kind of work	k done d	ation Juring most	of worki	ng I	16b. Kin	d of Busines	s Indu	stry
12	within giene.	5	Elementary/Seconday (0-12)	College (1-4 or 2	5+)	life. Do	O NOT use		WNER			RECA	T ATTT) E.	LECTRIC
	filed wi al Hygid d other event, t	B (17. Father's Name (First, Middle, Last)					Ť		er's Name	(First, Middle,			<i>)</i> L.	BECIRIO
an	ild be filk Mental narked o	<u> </u>	SIMON			HACK			ROS		h mad imadia)	,,,a,,,,,,		SSM	ΔΝ
Maryland	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type, Print)			a Address	(Street a			Route Number	r. Citv or T			
	12 sh aith ai 27 is rtrau		MIRIAM HACK / WI			l .	-				D, PIKI	-			
ē,	je 1 and t of Heal If item or other		20a. Method of Disposition			ace of Dispo	sition (Nam	e of	1		ate		ation - City		
Ë	Page nent c int: If		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		' I	emetery, cren ALTIMO	-			08/13	7/2010	RE1	STERS	TOW	N. MD
Baltimore,	permit. Page 1 and Department of I Important: If ite any injury or of once.	1	21. Signature of Funeral Service Licer	nsee			. Name and		-11/12/20		LEVINS				
Ω	e a m e e		atulke	ome			8900	REIS	TERST						D 21208
		8	23a. Part 1. Enter the disease, or con shock, or heart failure. List only	nplications that cause one cause on each lin	d the death	. Do not ente	er the mode	of dying	g, such as o	cardiac o	r respiratory arr	est,		lt.	pproximate nterval Between
1	Physician/		Immediate Cause (Final disease or condition	Metoca	todic	Do	House	_ CC	nco	-				1 8	Inset and Death
	Medical Examiner		resulting in death)	Due to (or as	a conseque										
	LAUIIIIICI	፟	Sequentially list conditions,	b										⊢	
	sit sit	edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as	a conseque	ence of):									
	cate be executed physician and the burial-transit	xa	that initiated events resulting in death) Last	c. Due to (or as	a conseque	ence of):								+	
	oe ex ician burial	<u>8</u>		•		,									
Box 68760	phys the			d											
88	ath certifica attending p	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of <u>pr</u> egnan	ncy						2	3d. Date of c	lelivery	į
XO	atter d for u	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live Birth 4 ☐ Pregnant	2 ∐ Fetal at time of de	death 3 L eath 5 C	Ectopic participation of the communication of the c	regnanc ecify)	y 				Month	-	ay Year
	that the dea led by the a detached t	Physician/M	9 🗆 Unknown	9 Li Unknown											
P.O.	that ned k		Part II. Other significant conditions	contributing to death I		_					23e. Did to	bacco us	1 6		cause of death?
ds,	v requires the special	Completed by	coloray orter	alsos	2,04	FUOJ.	+1/DV,	104	ra,		1 🗆 '	Yes 2] No 3.0€	Proba	bly 4 🗌 Unknown
Ö	w rec	plet	congestive has	ort fall	J.C.						24a. Was a		24b. Were a	autops	y findings available pletion of cause of
3ec	sician; The law certificate has b irector, page 2 s	mo;	9								perfo	rmed? 2 No	death?	?	
a	ysician; is certifica director, p	Be	25. Was case referred to medical examiner?					26. Pla	ace of Deat	h (Check			4		
of Vital Records,	Physic this ce al dire	힏	1 ☐ Yes 2 No			ER/Outpatien			4 ⊔ Nu	rsing Ho	ne 5 🗆 Resid	ience 6	Other (Spe	ecify)	tospice
J Of	Attending Physician: The law requires that the death certificate be executed are death. **redeath.** **ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transity the funeral director.	ate:	27. Manner of Death Natural 5 ☐ Pending	28a. Date of inju (Month, Da	ury ay, Year)	28b. Time of injury		lc. Injury work	?	- 1	8d. Describe h	ow injury	occurred		
jor	ttend death tor: / the f	til	2 Accident Investigation 3 Suicide 6 Could not		un. At has	no form stee	M factors		Yes 2 🗆	-	207 1 11 70	4	Alb		and Africa have
Division	after Direc	Certificate:	4 Homicide determined		c. (Specify)		et, factory,	Office			28f. Location (S City or Tow		Number or H	iurai Hi	oute Number,
	spital	cal	29a, Certifier 1 Certifying Phy	ysician: To the best of	f my knowle	edge, death o	ccured at t	he time,	date and p	olace, and	I due to the car	use(s) and	manner as s	stated.	
	To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director After this completed filled in by the funeral di	Medical	(Check 2 Medical Exam	niner: On the basis of e	examination	and/or invest	igation, in m	ny opinio	n, death oc	curred at	the time, date a	nd place, a	and due to the	e cause	e(s) and manner state ed.
	To the within To the Comp	-	29b. Signature and title of certifier						number				signed (Mor		
			Knocro J	um o	CRN	P	K	14	5350	D		Aug	US+ 1	5	2010
			30. Name and address of person who						0	,		7	^	<u></u>	1
		I .	Leman Vital	0 5551	1551	100	town	TP.V	KI	MIL	IOW.	an 1	(W)	21	20X4

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25989 State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death BALTIMORE NORTHWEST HOSPICE RANDALLSTOWN Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**XX**F Hours $J_{an}^{(Month}16^{Day}, Y_{an}^{ear})$ 39 CountryMARYLAND Director 217-34-5073 71 Usual Residence of Decedent permit. Page 1 and 2 should be flied within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2XXNo MARYLAND BALTIMORE RANDALLSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 3801 SNAPPER DR. APT 425 21133 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Bace - American Indian Armed Forces?

1 Yes 2 Armo Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK Completed 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) TELEPHONE COMPANY OPERATOR 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 JAMES WHITE ELIZABETH BELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bentalou St., Baltimore, Maryland 21216 Josie E. Ray Rock/Daughter 1505 N. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) GARRISON FOREST 08-24-2010 OWINGS MILLS, MARYLAND 21. Signature of John and Address of Facility
AM C BROWN COMMUNITY FUNERAL HOME P.A.
W NORTH AVENUE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Due to or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to for as a consequence of: the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery in the past 12 month 1 Yes 2 17 to Ectopic pregnancy 5 Other (specify) Month Dav Year Pregnant at time of death signed by the a d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 nknown cate has been sig ; page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe Director: After this certificate d in by the funeral director, pag 2 🗆 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending 1 Yes 2 🗆 No Investigation Accident Suicide 6 Could not be within 24 hours after de

To the Funeral Directo

completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9 MA 31. Date filed (Month, Day, Year) Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ nnson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Balto Northwest Hospice Randallstown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗶 F Months Days Hours MD **Director** 56 <u>216-62-1789</u> Usual Residence of Decedent 28a-f shov 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amay injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Directo 1 X Yes 2 No MD Baltimore na 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 210 S. Carey Street 21223 U S Α 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black Specify: Completed 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Unemployed 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mildred Lee Ballard James Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 210 S. Carey Street Balto, MD 21223 Charles Beaufort-Son 20a, Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Greenmount 1 ☐ Burial **XX**Cremation 3 ☐ Removal from State 8-24-2010 Balto, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March East F/H 21202 1101 E. North Avenue Balto, MD23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions Examine Due to (or as a consequence of): if any, leading to immediate Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last physician a s the burial-1 Physician/Medical Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Day 5 Other (specify) Month Year Pregnant at time of death 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy perform 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tes Other: 잍 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence Certificate:

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital 24 hours after death Funeral Director: A filled in by

Certificate	1 Natural 2 Accident 3 Suicide 4 Homicide	5 Pending Investigation	(Month, Day, Year) 28e. Place of Injury - At h. building, etc. (Specif	injury M ome, farm, street, facto	work? 1 Yes 2 No	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Medica	(Check 2	Medical Examine	 r: On the basis of examination 	n and/or investigation, i	n my opinion, death occur	e, and due to the cause(s) and manner as stated. ed at the time, date and place, and due to the cause(s) and manner stated. I place, and due to the cause(s) and manner as stated.

only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death	occurred at the time, date and place, and due to	the cause(s) and manner as stated.
29b. Signature and title of certifier	29c. License number DISST	29d. Date signed (Month, Day, Year)
	Aig Bon Blad	Suite N 2106,
31. Date filed (Month, Day, Year) 32. Registrar's Signature		

31. Date filed (Month, Day, Year) State

Registrar

within 24 hour To the Fune completed fi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Year Lucas 15 2010 08 Medical Joseph 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 4826 Briarcliff Road Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Days 1 🔀 M 2 🗆 F Months Hours Min. (Month, Day, Year) Director 74 213-32-4241 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 □ No Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21229 4826 Briarcliff Road "natural", or items 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian, , or þ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Clerk US Postal Service 2th grade 2yrs Be 18. Mother's Name (First, Middle, Maiden Surname) ည Washington Lucas Alice Joyce 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Briarcliff Road, Baltimore, Md 21229 Myrna Lucas-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition Burial 2 Cremation 3 Removal from State Memorial Park 8/20/2010 Woodlawn, Md 4 ☐ Donation 5 ☐ Other (Specify) King 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
March F/H West
4300 Wabash Av 0 21215 Baltimore, Ave, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final ETAS 1000 CANCER THTIC Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury Duri to for as a nonsequence of: Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for ا in the past 12 months? Month Year 5 Other (specify) Yes 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown detached Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ sign Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, p Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending work' 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

To the

29a. Certifier

29b. Signature and title of codi

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

DHMH 17 Rev 7/2009

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Praytioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

10061765

of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

350 WILTIS AVE #307 BALT.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Aug. 14, 2010 Kalliopi Noi LeVanis Рм 5:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner Baltimore** 2122 Belfast Road Sparks 8. Date of Birth May 9, 1938 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F Days Hours Greece' Director 219-44-7985 72 Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 X No Sparks Md. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21152 USA 2122 Belfast Road death 1 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XX No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 72 hours after 1 Yes 2 X No Specify "natural", Specify. 3 X Widowed 4 ☐ Divorced Completed White Year or Dates event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 4 Interior Designer Home Decor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eugenia Strogilos George Kakanis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2122 Belfast Road Sparks, Maryland 21152 Paul LeVanis/Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ★ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Dulaney Valley Mem. Grds. 8/19/10 Timonium, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final sclerosis Physician/ 40 tro disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or linjury that initiated events Exami or Attending Physician; The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 the SB IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year g 🗌 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ þe 2 No 3 Probably 4 Unknown Division of Vital Records, 1 🗌 Yes Completed peen 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? has performed certificate 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital 2 No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death.

Funeral Director: After this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 2 Accider injury 5 Pending Accident Investigation completed filled in by the Suicide 6 Could not be 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) pate signed (Month, Day, Year) 29c. License number

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who

AUG 192010

ompleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

6701 N. Charles

		•	For State Registrar	State of Maryland		irtment of F tificate of D		vientai Hygie Reg.	2010	25993		
	Physicia	n/	1. Decedent's Name (First, Middle, Las	1				2. Date of Death Month	Pay 2010 Year	3. Time of Death 7:50 A M		
	Medic Examin		4a. Facility Name (if not institution, give	Leneau street and number)		4b. City, Town, or	Location of Death		4c. County of Death			
. 100,	Funeral		3500 Edgewood Koad Baltimore [5. Social Security Number] 6. Sex 77. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. E									
	Director		250-34-2207 1	□M2 12/F 8	6 Yrs.	Months Days	Hours Min.	8. Date of Birth (Menth, Day, Ye	723 Cou	hplace (State or Foreign intry)		
	land show dat	tor	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Loc					10d. Inside City Limits		
	e Mary r 28a-f notifie	Direc	10e. Street and Number	159	1tim	10f. Zip Code		10-	. Citizen of What Co	1 ☑ Yes 2 ☐ No		
	s 23a o	Funeral Director	3500 Edge	wood Rug	d	218	215	Tog	USA	untry :		
~	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fur	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No			ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White			
0036	urs afte tural", al Exan	ted b	3 Widowed 4 Divorced	If Yes, Give Year or Dates.		Yes 2 No			Specify: B	lack		
215-	n 72 ho an "nat Medica	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Şeconday (0-12)		(Give k	ent's Usual Occup ind of work done o NOT use retired)	ation during most of work	king 16	b. Kind of Business I	ndustry		
7	d withi	Be Co	17. Father,'s Name (First, Middle, Last)	conego (r. 15. 51.)	Buil.	ding 1	<u>Nanaa</u>	er L ne (First, Middle, Maid	Salto. Ci	ty Schools		
/land	d be file Mental I arked o rtic eve	ē	Warren Sca	H)	alma		1/3			
Baltimore, Maryland 21215-0036	12 should be f lith and Menta 27 is marked r traumatic ev		19a, Informant's Name/Relationship (Ty	/Ca.			and Number or Ru	ral Route Number, Cit	y or Town, State, Zip	Code)		
re, l	of Health of Health of item 27 or other tr		20a. Method of Disposition	/ / /		o CATN sition (Name of natory or other place	STOOK	Date 20	C Location - City or	Town, State		
timo	permit. Page of Department of Important: If any injury or once.		1 🗹 Burial 2 🗆 Cremation 3 🗆 4 🗆 Donation 5 🗀 Other (Specify) G	arris	on Fore	st 8-2	4-2010 6	Wings/	nills mo		
Ba	permit. Departr Importa any inju		21. Signature of Funeral Service Licens	Drune	8	Name and Address	erturio			ma Services Mn 21133		
L			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or	ne cause on each line.		-	-	or respiratory arrest,		Approximate Interval Between Onset and Death		
1	hysician/ Medical	Immediate Cause (Final disease or condition resulting in death) a. a. Atheroscle notic Cardiovascular disease Due to (or as a consequence of):										
	Examiner	<u>.</u>										
-	rted 1 ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury									
	ate be executed physician and the burial-transit	al Ex	that initiated events resulting in death) Last	Due to (or as a conseque	ence of):							
3760	ficate b g physic as the b	Aedical		d								
% 68	th certi ttendin or use a	ian/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnan	death 3 _	Ectopic pregnand Other (specify)	су		23d. Date of del Month	ivery Day Year		
Division of Vital Records, P.O. Box 68	requires that the death certific been signed by the attending should be detached for use as	Physician/N	1 Yes 2 No 9 Unknown	4 ☐ Pregnant at time of de 9 ☐ Unknown	aun o L	Other (specify)						
, P.O	es that signed l	l by F	Part II. Other significant conditions of dementa, d		-		en in Part I.		co use contribute to	the cause of death?		
ords	v requir s been s	Completed by	huperlipide	. / //	. , . , .			24a. Was an	24b. Were aut	opsy findings available completion of cause of		
Rec	The lay	Com						autopsy performed 1 Yes 2	d? death?	2 No		
Vital	ysician: s certifi	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatien	Othe	ace of Death <i>(Chec</i> er: 4 □ Nursing H	ome 5 K Residenc	e 6 Other (Speci	ítv)		
of	ing Phy I. After this uneral o		27. Manner of Death 1. Natural 5 Pending		28b. Time of injury	28c. Injun work	y at	28d. Describe how i				
Sior	Attend or death octor: A	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hon	ne, farm, stre		Yes 2 No		t and Number or Rur	al Route Number,		
<u>></u>	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi completed filled in by the funeral director, page 2 should be detached for use as the burial-transi			building, etc. (Specify)				City or Town, S				
	ne Hospin 24 hos	Medical	(Check 2 Medical Exami	ician: To the best of my knowle ner: On the basis of examination e Practioner: To the best of my	and/or investi	igation, in my opinic	on, death occurred	at the time, date and p	lace, and due to the o	ause(s) and manner stated.		
	To th		29b. Signature and title of certifier	le Goldbioon	nn	29c. License	3968	29d.	Date signed (Month	, Day, Year) 6 2010		
			30. Name and address of person who o		/		112 #1	m A	100001	6,2010 MD 21117		
	Circ		Elle Goldblool 31. Date filed (Month, Day, Year)	M 21 C 32/Registrar's Signatu	100		ive #4	UU WIV	igs IVIIIV	110 2111+		
	Stat Registra		AHG 1 9 201		boa	Mal						

		_	7 01	ryland / Depart			lental Hyg	iene	05001			
			State Registrar	Certii	ficate of D	Death		eg. No.ZUIU	25994			
	Physicia		1. Decedent's Name (First, Middle, Last) Gwendelvn A. Lew	ic			2. Date of Deat Month	Day - JOIO	3. Time of Death 2.08 P M			
	Medic Examin		a. Facility Name (if not institution, give street and number)		b. City, Town, or	Location of Death	<i>D</i>	4c. County of Death				
-	Ŕ.		Stella Maris 5. Social Security Number 6. Sex 77. Age	(In yrs. last birthday)	In Under 1 Year	If Under 24 Hrs.	8. Date of Birth		hplace (State or Foreign			
	Funeral Director		217-40-0865 1 □ M 2 8 F		Ionths Days	Hours Min.	(Month, Day,	Year 45 Cou	intry) mb			
	nd at	'n	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Locati	ion				10d. Inside City Limits			
	Aarylar 8a-f sh tified a	recto	mi) Baltimace	0 / 1/	town				1 ☐ Yes 2 ☑ No			
	e filed within 72 hours after death with the Maryland ital hygiene. So dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number		10f. Zip Code		1	10g. Citizen of What Cou	untry?			
	ems 2	uner	11. Marital Status 12. Was Decedent Ev	ver ja-tJ.S. 13. Was	J//3 Decedent of Hi	spanic Origin? (Spec	cify Yes or No-	14. Race - Amer	ican Indian.			
• ⊞ •	ifter de ", or it amine	by	1 ☐ Never Married 2 ☐ Married Armed Forces? 1 ☐ Yes 2 ☐ 1	If Ye	es, specify Cubar	n, Mexican, Puerto F	Rican, etc.)	Black, White				
- ö	nours a aturali cal Ex	eted	3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education		t's Usual Occupa			16b. Kind of Business I	acr-			
::08 p.m 215-0036	iin 72 h ie. han "n e Medi	Completed	(Specify only highest grade completed) Elementary/Seconday (0,12) College (1-4 or 5-	(Give kind life, DC 1	d of work done d OT use retired)	uring most of workir	ng	11-11	<i>C</i> -			
2	ad with Hygien other tl ant, the	a) f	17. Father's Name (First, Middle Last)		are e	18. Mother's Name	/First Middle N	17ea 17h	Care			
2010 rylanc	Q 12 2 0	인	William J. Franks			Elizab		Clark				
6, 2010 Maryland	sho is is		19a. Informant's Name/Relationship (Type, Print)	1	1 -1	and Number or Rural	Route Number,	City or Town, State, Zip	Code)			
16 re, N	1 and 2 of Health item 27 other to		James F. Lewis Husber 20a. Method of Disposition	20b. Place of Dispositi				Ac (15 to W), 20c. Location - City of	700 71133 Town, State			
AUGUST 1 Baltimore,	. O		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	metery, cremate (TACI 1501	-	st 8-3	5-2010	Duines M	ills mu			
AUG Balt	permit. Page Department Important: I any injury o		21. Si natur of Funeral Service Licensee			s of Facility Vave	ha C. Gr Randa	Ilstorn, mi				
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line.	the death. Do not enter the	he mode of dying	g, such as cardiac of	r respiratory arre	est,	Approximate Interval Between Onset and Death			
	Pnysician/ Medical	6 6	reculting in death)	ASCULAR ACC	IDENT				Onset and Death			
	Examiner	L	Due to (or as a consequence of):									
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause (Disease or linjury									
	be executed iician and burial-transit		that initiated events resulting in death) Last Due to (or as a consequence of):									
09	ate be (hysicia the bur	dical	d		<u></u>							
687	certifica Iding p	n/Me	F FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of					23d. Date of deli	ivery			
. Box 687	sician: The law requires that the death certificate be execut certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-trar	Physician/Me	in the past 12 months? 1 ☐ Yes 2 🛣 No 9 ☐ Unknown		ctopic pregnanc other (specify)	у		Month	Day Year			
GWENDOLYN LEWIS of Vital Records, P.O.	is that the gned by be detail	by	Part II. Other significant conditions contributing to death bu	t not resulting in the unde	erlying cause giv	en in Part I.		pacco use contribute to				
LEWIS ords, P.	require been s should	leted					24a. Was ar	es 2 No 3 Pr	opably 4 🔼 Unknown opsy findings available			
GWENDOLYN of Vital Reco	he law te has age 2 :	Completed					autops perform 1 \sum Yes	y prior to c	completion of cause of			
MD0	cian: T ertifica ector, p	Be	25. Was case referred to medical examiner?		26. Pla	ace of Death (Check						
SVE SYE	Physi r this c sral dire	<u>≥</u> 10	1 ☐ Inpatie 27. Manner of Death 28a. Date of injur	nt 2 ER/Outpatient 28b. Time of	3 DOA Other	4 U Nursing Hor		ence 6X Other (Speci w injury occurred	fy) HOSPICE			
	e nding sath. or: Afte he fune	ficat	1 X Natural 5 ☐ Pending (Month, Day, 2 ☐ Accident Investigation	Year) injury	M 1 □	? Yes 2 □ No						
Division	or Att after de Directo	Certificate:	3 ☐ Sulcide 6 ☐ Could not be determined 28e. Place of Injurbuilding, etc.	y - At home, farm, street, (Specify)	, factory, office	1	28f. Location (Str City or Town	reet and Number or Run , State)	al Route Number,			
Δ	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of ronly one) 3 Certifying Nurse Practioner: To the best of	amination and/or investiga	ition, in my opinio	n, death occurred at	the time, date and	d place, and due to the c	ause(s) and manner stated.			
	To the within To the compl	2	29b. Signature and title of certifier	IAAN	29c. License			9d. Date signed (Month	, Day, Year)			
			st metine vo	411 , 141)	INS	2140		trugust	17th 2010			
X			 Name and address of person who completed cause of de ERNESTINE WRIGHT, MD 2300 			. TIMONT	UM, MD 2	21093				
×	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar		/							
1	. regioni		HUU A II GUIU	- '-								

Registrar DHMH 17 Rev 1/2001

State

ec

14

600 North Wolfe St, Baltimore, MD, 21287

M.D

32. Registrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NarL

venzata 31. Date filed (Month, Day, Year)

AUG 192010

0

Physician /Medical **Examiner** Hospital or Attending Physician: The law requires that the death certificate be executed

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

Funeral

Director

ms 23a or 3 must be n

h and Mental Hygiene.

permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tra

Pages 1 and 2 should be

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

physician and s the burial-tran After this

Division or Vital Records, P.O. Box 68760

Physician/Medical þ Completed Be

Certification: To

Medical

1 ☐ Yes 2 ☑ No 27. Manner of Death 1 Natural

29a. Certifier

2 Accident 3 ☐ Suicide 4 Homicide

6 ☐ Could not be

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

D0061789.

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

I 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

mHwud-30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LORPAINE OF ORI-AWUAH, MD. 5430 CAMPBELL BLVD, STE 214. BALTIMORE MD21236 32 Registrar's Signature

State

DHMH 17 Rev 1/2001

within 24 hours after death To the Funeral Director:

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010

		1- For State Certificate of Death Reg. No.								
Physiciai dical Examin	n/	1. Decedent's Name (First, Middle, Last) Kenneth Missouri 2. Date of Death Month Day August 4, 2010	3. Time of Death 0740 hrs							
*		Northwest Hospital Randallstown Baltimore Co	4c. County of Death Baltimore County							
Funeral Director		5. Social Security Number 6. Sex 217-86-4770 1 Mm 2 F 46 Yrs. Security Number 217-86-4770 1 Months Days Hours Min. 6. Sex 36-30-1964 Fore C								
rath with the Maryland frems 23a or 28a-f show any let motified at once.	_	Usual Residence of Decedent 10a. State MD 10b. County Baltimore	10d. Inside City Limits							
the Maryl. a or 28a-f	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Cot 1 Comill Court 21117 U S A	untry?							
ter death with	Funeral	11. Marital Status 1	Black							
2 hour	mpleted	pleted by	pleted by	pleted by	pleted by	npleted by	npleted b	npleted by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade Tor Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) n a	Industry
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica		17. Father's Name (First, Middle, Last) Charles Missouri 18. Mother's Name (First, Middle, Maiden Surname) Geraldine Gary								
MD 21 nd 2 should 1 alth and Mer m 27 is mar aumatic ev		19a. Informant's Name/Relationship (Type, Print) Ashley Missouri-Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 2516 Harford Road Balto, MD 212								
Baltimore, I bernit. Pages I and Department of Heali Important: If item njury or other tra		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) Lorraine Park 20c. Location - City or Specify Balto								
Balti permit. Departn Imports		21. Signature of Fugeral Service Licensee 22. Name and Address of Facility Match F/H	D 21212							
Physician //Medical Examiner		23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease a. Seizure Disorder Associated with Cerebral Vascular or condition could be a caused.	Approximate Interval Between Onset and Death							
	١	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of):	tion							
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of):								
execur an and al - tra	Medical E	© UNPENDED	t							
	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	ry Day Year							
P.O. B s that the d	ᆰ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to	the cause of death?							
Division of Vital Records, P.O. Box 68. To the Hospital or Attending Physician: The law requires that the death certificath ours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Completed		utopsy findings available completion of cause of							
Vital Recysician: The his certificate director, page	10 Be	25. Was case referred to medical examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Other	er.							
ision of Attending Pher death.		27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No								
Divising the Attended on the A	Certification:	Suicide 6 Could not be determined Specify Suicide 4 Homicide Could not be determined Specify S	ural Route Number, City							
To the Hospita within 24 hours To the Funcral completely fille	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the and manner stated.								
	Ž	29b. Signature and title of certifier 29c. License number 29d. Date signed (Mo August 5, 2010	onth, Day, Year)							
		30. Name and address of person who completed cause of death (Item 23a). Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201								
Stat	te	31. Date filed (Month, Pry Gear) 2010 32. Registrar's Signature								

			For State	tate of Maryland / Dep		Mental Hygie	ene	05000		
			Registrar 1. Decedent's Name (First, Middle, Last)	Ce	rtificate of Death	25998				
	Physicia Medi	cal	Delones 1	hen pours		2. Date of Death	196 Z810	645 Th		
	Examir	ner	4a. Facility Name (If not institution, give street	, and the second	4b. City, Town, or Location of Dea		4c. County of Death			
	Funeral	г	Northwest Season 5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	Randallstown		Balti	More ace (State or Foreign		
	Director		212-36-2457 1 DM		Months Days Hours Mi	Month Day, Ye	38 Counti			
	nd how at	٦	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation					
	larylar Ba-f sl ified	ecto	MD NA	Baltimo			110	ld. Inside City Limits 1 Yes 2 □ No		
	the M	Ē	10e. Street and Number		10f. Zip Code	10g	. Citizen of What Count			
	s 23a	Jera	874 W. Lombard S	treet	21201		USA	•		
	death r item iner n	/ Fui	, , , , , , , , , , , , , , , , , , ,	Armed Forces?	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - America	n Indian,		
21215-0036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho er the Medical Examiner must be notified at	Completed by Funeral Director	2X Midawad 4 Dhanad	l ☐ Yes 2 🛣 No f Yes, Give ∕ear or Dates.	1 ☐ Yes 2 🛛 No Specify:	,		· African rican		
2-0	hour hatur dical	olete	15. Decedent's Educati (Specify only highest grade co	on 16a. Dece	dent's Usual Occupation	16	b. Kind of Business Inde			
2	filed within 72 tal Hygiene. d other than ' event, the Me	mo	Elementary/Seconday (0-12)	College (1-4 or 5+)	kind of work done during most of wo OO NOT use retired)	orking				
i D	ed wit Hygie other	BeC	8th Grade 1 17. Father's Name (First, Middle, Last)	NA Lab	orer		weet Hear	t Cup Co		
Maryland	should be file and Mental is marked c	2	York Candy		Roset	ame (First, Middle, Maid ta B	den Surname) POWN			
lary	should be n and Ment 7 is marked raumatic e		19a. Informant's Name/Relationship (Type, Pr		ng Address (Street and Number or F	ural Route Number, Cit	y or Town, State, Zip Co	ode)		
e o`	and 2 Health tem 27		Deborah E. Ruffin 20a. Method of Disposition		W. Lombard St	reet Bal	timore, M	D 21201		
Baltimore,	Page 1 nent of ant: If it		1 Burial 2 □ Cremation 3 □ Remoderation 5 □ Other (Specify)	oval from State 20b. Place of Dispo cernetery, cre Garriso	natoni or other place)		c. Location - City or Tow ${\sf wings}\ {\sf Mil}$			
Balt	permit. Departr Importa any inju		21. Signature of Funeral Service Licenses		2. Name and Address of Facility 38 N. Gilmore	Wylie Fur Street Ba	neral Hom	e P.A.		
			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cau	ons that caused the death. Do not ent			,	Approximate		
-5	h, sician/		Immediate Cause (Final disease or condition	Canco-	Sallb/an	100		nterval Between Onset and Death		
	Medical Examiner		resulting in death)	Due to (or as a consequer ce of):		7				
	100	Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):						
	uted d ansit	Examiner	Cause (Disease or linjury that initiated events c							
	ian an irial-tr	E	resulting in death) Last	Due to (or as a consequence of):						
09	icate be executed g physician and is the burial-transit	edical	d							
89	certificate be executed nding physician and use as the burial-transi	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If	yes, outcome of pregnancy						
Rox	death c he atten ed for u	icia	in the past 12 months?	Live Birth 2 Fetal death 3 Pregnant at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of delivery Month D	ay Year		
	v requires that the death certific been signed by the attending I should be detached for use as	Physician/M	g Unknown	Unknown						
	es tha signed be de	ρ	Part II. Other significant conditions contribu	ting to death but not resulting in the u	nderlying cause given in Part I.		co use contribute to the			
Vital Records,	requir been s	Completed					2 No 3 Proba			
ပို့ .	e law e has ige 2 s	dmc				24a. Was an autopsy performed	prior to comp	y findings available pletion of cause of		
r i	an: Ih tificat tor, pa		25. Was case referred to medical		26. Place of Death (Che	1 🗆 Yes 2		No No		
\ \frac{1}{2}	nysici iis cer direc	10 B	examiner? 1 Yes 2 No Hospita	al: 1 ☐ Inpatient 2 ☐ ER/Outpatier	Other	Home 5 Residence	6 ☐ Other (Specify)			
0 '	ing Pi		27. Manner of Death 28 1 ✓ Natural 5 ☐ Pending	Ba. Date of injury (Month, Day, Year) 28b. Time of injury	28c. Injury at work?	28d. Describe how in				
VISION	ttend death stor: A / the f	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	o Place of Irium. At home forms to	M 1 ☐ Yes 2 ☐ No					
֓֞֟֝֟֝֟֝֟֝֟֝֟֝֟֝֟֟֝֟֟֟֝֟֟֟֟ ֓֓֓֓	Ital or A		To Holling determined	e. Place of Injury - At home, farm, stre building, etc. (Specify)		City or Town, Sta	,	oute Number,		
	To the hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	Medical	(Check 2 in Medical Examiner: Or	To the best of my knowledge, death on the basis of examination and/or invest stioner: To the best of my knowledge, or	igation, in my opinion, death occurred	at the time date and pla	aco, and due to the equipo	e(s) and manner stated.		
	with To t		29b. Signature and title of certifier	7/2	29c. License number		ate signed (Month, Da			
			198000	VILAN	N15870	5 /7	usud)	1,2010		
			30. Name and address of person who complet	ed cause of death (Item 23a) (Noe, P	FASIN BI	lud Sus	do No	1061		
	State Registra	-	1. Date filed (Month, Day, Year)	3. Registrar's Signature	Kel	/_		, , , ,		

			F	Pleas	se Type or Pri			ndelible Inloartment of			-			ole.		
		1	a POI										Reg. No. 2010 259			
Dhu	. I a I a u		1. Decedent's Nam	e (First, Middle,	Last)						2. Date of Death Month Day			Voor	3. Time of Death	
	sician edical		Mary G	eraldin	e Martindal	.e				!	AUGUS	7 10		Year 010	7:35 PM	
Exa	miner	ľ			give street and number)			4b. City, Town,		n of Death		4c.	County	of Death		
	1		5. Social Security N		EL AIR 3. Sex 7. AC		last birthday		Air	er 24 Hrs.	8. Date of Bi		AR		lace (State or Foreign	
Fune Direc			220-18-7		1□M 2 ∑ F	85	Yrs.	Months Days		Min.	" (Month, D	ay, Year)	925	Cour	ntry)	
P.		-	Usual Residence of	f Decedent							oune 1	4, L	925		yland	
arylar show			10a. State	10b. County			y, Town or L	ocation						1	0d. Inside City Limits	
th the Marylan or 28a-f show	Director		Maryland 10e. Street and Nur	Harf	ord	Bel	Air	10f, Zip Code				10= Cit	izen of W	That Cause	1⊠Yes 2□No	
5-0036 72 hours after death with the Maryland Instural", or items 23a or 28a-f show				onzen D	rivo			2101	1					nat Cour	uyr	
death	Funeral	-	11. Marital Status	Olizeli D	12. Was Decedent	Ever in U.	S. 13.	Was Decedent of If Yes, specify Cu		Origin? (Spec	cify Yes or No	U		- Americ	an Indian,	
36 after or ite	3		1 Never Married 2 Married I Yes 2 XN			No		1 ☐Yes 2 XNo			lican, etc.)			, White, e	etc.	
000 nours	yd b		3 Widowed		Year or Dates:					·y.			Specify:	Whit		
15- n 72 "nat	Completed	ţ			Education grade completed)		(Give	edent's Usual Occu e kind of work done DO NOT use retin	durina ma	ost of working	g	16b. Ki	ind of Bus	siness/Ind	dustry	
212 I with giene.	I I		Elementary/Seco	ndary (0-12)	College (1-4or 5	5+)		stant Pr	/	or		Medi	ical	Educ	ation	
nd nd al Hys l othe	Be		17. Father's Name	(First, Middle, La					18. Mot	her's Name	(First, Middle					
ylal ylal Ment Ment erkec	<u> </u>		John Jos	eph Mor	gan				Mar	garet	(nmn)	McKe	Kenna			
Aar 2 sho h and ' is m		ŀ	19a. Informant's Na	ame/Relationship	(Type. Print)		19b. Mail	ing Address (Stree	t and Num	ber or Rural	Route Numb	er, City o	r Town, S	State, Zip	Code)	
timore, Maryland 21215-0036 I. Pages 1 and 2 should be filed within 72 hours aft trent of Health and I hental Hygiene. The strip in a 78 in merked other trainmain event in the strainmain event in the strainmain event.		-	Robert M 20a. Method of Disp		le / Son	20h B		Cannery 1		Fores					wn, State	
nor nor ages ant of t: If it			1 🔀 Burial 2 [Cremation 3	Removal from State			osition (Name of matory or other pla	i							
timore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene.	οú	h	4 □ Donation 21. Sig t re of Fu	5 □ Other (Spe	-	Mtr		ristian C 2. Name and Addr		8-20-			opa,	Mary	<i>r</i> land	
Deb Deb	ouce	21. Signate and Address of Facility McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, MD 21014														
												Approximate Interval Between				
hysicia ^ر ۔	n	ı	Immediate Cause (disease or conditio	Final	_a Acut		veca	RDIAL	INFA	RETI	2 1 1				Onset and Death	
/Medic	-		resulting in death)		Due to (or as			KOTAC	1	WE IT	70					
LAdillii		Sequentially list conditions, if any, leading to immediate cause. Enner Unicerlying Cause (Disease or injury														
uted nsit	Examiner															
50, be executed cian and urial-transit	Exai	1	that initiated events resulting in death) L		c Due to (or as	a consequ	ence of):									
18760, icate be ex physician stree burials					d											
I Records, P.O. Box 68760, The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burist-transit	Physician/Medical		IF FEMALE:									- 1		- 3		
Box 68 leath certific attending pl	an/I	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy								2	23d. Date of delivery Month Day Year					
P.O. I at the ded by the a stached for	ysic		1 □ Yes 2 2 9 □ Unknown		4 ☐ Pregnant a 9 ☐ Unknown	t time of d	eath 5	Other (specify)					WIOII	1111	Day fear	
, P. (that the ted by detac	-Ph	F		icant condition	s contributing to death be	ut not resu	lting in the u	ınderlying cause gi	ven in Part	ı I.	23e. Did t	tobacco u	ise contri	bute to th	e cause of death?	
Division of Vital Records, Full or Attending Physician: The law requires that after death. Director: After this certificate has been signed in by the funeral director, page 2 should be determed by the funeral director, page 2 should be determed in the page 2 should be determed to the page 2 should be determed to the page 2 should be determed to the page 2 should be determed to the page 2 should be determed.	Completed by	` <u>_</u>	CORONA	RY AR	TERY DISE	ASE	H	PERTEN	SION	/	1 🗆	Yes 2[□ No	3□ Prob	ably 4 Unknown	
eco aw rec as bee 2 shou	olete	1	CHRON	le KID	NEY DISE		/	IEMIA			24a. Was	an	24b. W	ere autor	osy findings available	
The lay	E O	autopsy performed?								psy ormed? 2 DNo	prior to completion of cause of death?					
f Vital F ysician: Th is certificate director, pag	Be C		25. Was case referr examiner?	ed to medical					26. Plac	ce of Death (1 □Yes (Check only o		1		2 LIN0	
vision of Vital Attending Physician: r death. ector: After this certifica			1 ☐ Yes 2 📆					III 3 L DOA		Nursing Home	e 5 ⊟ Resi	dence 6	6 □Othe	r <i>(Specif</i>))	
On C	j Ü	2	27. Manner of Death 1. Natural	5 Pending	28a. Date of Inju (Month, Day	ry y, Year)	28b. Time o Injury	Wo			d. Describe	how injur	y occurre	d		
isio	licat	l	2 ☐ Accident 3 ☐ Suicide	investigat 6 □ Could not	be 280 Place of Init	ırv - At ho	me farm st	M 1 C]Yes 2[of Location /	Ctract on	d Numbo	a o a Duro	Route Number,	
Div al or A s after al Dire	Certification: To	l	4 Homicide	determine	building, etc	. (Specify	<i>')</i>	out, ladioly, dilloc			City or To	wn, State,)	i oi nuia	Houle Number,	
hours hours ineral		1	29a. Certifier	1 Certifying	Physician: To the best	of my know	vledge, dea	th occurred at the t	ime, date a	and place, ar	nd due to the	cause(s)	and mar	nner as s	ated.	
To the Hours after determine 24 hours after determine 24 hours after detected to the Funeral Directed completely filled in by the	Medical		(Check only one)	2 Medical Ex	aminer: On the basis of and manner sta	f examinat ited.	ion and/or ir	nvestigation, in my	opinion, de	eath occurred	d at the time,	date and	l place, a	nd due to	the cause(s)	
Vith To t	Σ	2	29b. Signature and t	title of certifier	1			29c. Licen	se number			29d. Dat	e signed	(Month, I	Day, Year)	
			/	y years	capen 1	MD		104	534	4		8/	13)	201	0	
			0. Name and addre	ss of person wh	of completed cause of de	eath (Item	23a) (Type,	Print)		1/ 411 = -		0.4=	,	100		
	State	3	SURESH 31. Date filed (Monta	h, Day, Year)	2010 April 2010	6 2 ar's Signat	ure,	UNION A	VE /	MAYRE	DE G	KACE	1	102	10/8	
	strar			AUG 19	2010 Dense	w	A. A	arte								
DUMU 17 Pay	1/2001	_		V	178	-	4/									

		,	For State		State of Ma	aryland	d / Depa	rtment of l tificate of l	Health	and N	/lental Hy			0	26000)
			Registrar 1. Decedent's Name (Fire	rst, Middle, Last)			Cer	incate or i	Jeaui		2. Date of De	Reg. No ath			3. Time of Death	
******	Physicia Medic	cal	4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Dear									d 16	201		125A N	1
No.	Examir	ier	SEASONS HO	_		T HOS	SPITAL	4b. City, Town, o					County of D			
	Funeral		5. Social Security Number	er 6. Sex		e (In yrs. la	st birthday)	If Under 1 Year Months Days	If Under	r 24 Hrs. Min.	8. Date of Bir			Birthpl Co <i>u</i> ntr	ace (State or Foreign	n
	Director		219-42-592 Usual Residence of Dece		X	85	Yrs.				03/11/	1923			MD	
	ryland -f sho	Director		b. County	_		, Town or Loc							10	d. Inside City Limits	
	he Ma or 28a e notif	Dire	MD 10e. Street and Number	BALTIMOR	KE	BAI	TIMORI	10f. Zip Code				10a. Cit	izen of What	Count	1 ☐ Yes 2X No	0
	s 23a sust be	Funeral	7218 PARK	HEIGHTS	AVENUE,	#314	·		2120	8			USA			
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ξ.	11. Marital Status 1 Never Married	2 Married	2. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐X If Yes, Give		If	/as Decedent of H Yes, specify Cuba ☐ Yes 2 🗓 No	an, Mexica	in, Puerto	ecify Yes or No- Rican, etc.)		14. Race - A Black, W	hite, et	c.	
21215-0036	ours a atural	Completed	3X Widowed 4 ☐	Divorced Decedent's Educ	Year or Dates.			ent's Usual Occup					Specify: nd of Busine	WHI		_
215	iin 72 h ie. han "n e Medi	dwo		only highest grade		+)	(Give k life. DC	ind of work done of NOT use retired)	durina mos	st of worki	ing				astry	
	ed with Hygien other t	Be	12 17. Father's Name (First,	Middle, Last)			HOM	MAKER 18. Mother's Name (First, Middle, N					OWN HOME			
/lan	d be fill dental rrked o	户	OSCAR			STRA	USS		RI		e (i iist, iviidale,	maideri	odiname)		BEAR	
Maryland	should I and I is ma		19a. Informant's Name/F				· ·	Address (Street							,	
re,	1 and 2 s f Health item 27 other tra		LAWRENCE 20a. Method of Disposition	ion			ace of Dispos	STREAM (Date		cation - City		21209	_
Baltimore,	Page ment o ant: If ury or		1 🕅 Burial 2 □ Ci 4 □ Donation 5 □	remation $3 \square Recify$	emoval from State			atory or other place AVAS CHES		08/1	7/2010	RA	NDALLS	TOW	N, MD	
Balt	permit. Depart Import any inj		21, Sign fure of Funeral	Service Licensee	uhu)		Name and Addre			OL LEVI ROAD, P					
			23a. Part 1. Enter the di shock, or heart fail	lure. List only one	ations that caused cause on each line	the death	. (-	/		s cardiac o	or respiratory ar	rest,			Approximate Interval Between	
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a.	Due to (or as a	brak		um bo-	1					1	Onset and Death	_
- Paris and S	Examiner	L	Sequentially list conditions, b.													
	ad sit	Examiner	if any, leading to immed cause. Enter Underlying Cause (Disease or iinjun	diate	Due to (or as a	conseque	ence of):									
	icate be executed physician and s the burial-transit		that initiated events c. Due to (or as a consequence of):								+		_			
260	ate be ohysicis	edical		d.										_		_
687	certifica nding p	n/Me	IF FEMALE: 23b. Was decedent pregi	inant 230	c. If yes, outcome o								23d. Date of	deliver	v	_
. Box 68	he death y the atter ched for u	Physician/M	in the past 12 month 1 ☐ Yes 2 No 9 ☐ Unknown	ths?	1 Live Birth 2 4 Pregnant at 9 Unknown			Other (specify)	у				Month)ay Year	
P.0.	s that t gned b be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
space	require been si should	leted									1				bly 4 Unknown	
Records,	sician: The law I certificate has b lirector, page 2 s	Completed									autor perfo		prior death	to com ?	pletion of cause of	
ıta I	sician: certifici lirector,	To Be	25. Was case referred to examiner? 1 ☐ Yes 2 🔀 No	11-	spital:		:R/Outpatient	Oth	ace of Dea				To He	حرد	p' 9	—
Division of Vital	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		27. Manner of Death	Pending Investigation	28a. Date of injur (Month, Day,	у 2	28b. Time of injury	28c. Injury	y at		me 5 Resident			есну		_
ivisio	l or Atter after dea Director	Certificate:		Could not be determined	28e. Place of Inju building, etc.		ne, farm, stre	et, factory, office			28f. Location (S City or Tow		Number or i	Rural F	Poute Number,	
_	Hospita 24 hours Funeral leted filled	ledical	(Check 2 ☐ N	Medical Examine	An: To the best of r r: On the basis of ex Practioner: To the b	amination	and/or investig	gation, in my opinio	on, death o	ccurred at	the time, date a	nd place,	and due to the	ne caus	e(s) and manner state	ed.
	To the Comp	Σ	29b. Signature and title			Jook Of Thy	10 0	29c. License		o and plac	o, and due to th		e signed (Mo	nth. Da	av. Year)	_
			- Q	00	280V	ath //1	27/7)	D	158	7.	2	Huy	nd	10	, 2010	_
			30. Name and address of	BUR	ma.	493	Y A	14 h1.	~!	3/20	/ Su, à	61	V:	2/	061	
	Stat Registra	e ir	31. Date filed (Month, Pay	§ 2010	32. Registra	r's Sanatu	park									